

Audit Report
Delta Dental Insurance Company
January 1, 2013 – December 31, 2013



Prepared Under Contract With:
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April 2014

The Legislative Audit Committee
of the Montana State Legislature:

Enclosed is the report on the audit of the Delta Dental insurance claims for the State of Montana employee benefits plan for the plan year ended December 31, 2013.

The audit was conducted by Claim Technologies Incorporated under a contract between the firm and our office. The comments and recommendations contained in this report represent the views of the firm and not necessarily the Legislative Auditor.

The agency's written response to the report is included in the back of the audit report.

Respectfully submitted,

/s/ Tori Hunthausen

Tori Hunthausen, CPA
Legislative Auditor

13C-09

COMPREHENSIVE CLAIMS ADMINISTRATION AUDIT

EXECUTIVE SUMMARY

State of Montana

Administered by: Delta Dental Insurance Company
Audit Period: January 1, 2013 to December 31, 2013

Presented to:

State of Montana

April 14, 2014

Private and Confidential

Presented by:

Claim Technologies Incorporated

Preface

This Executive Summary consolidates important findings from each of the four separate components of Claim Technologies Incorporated's (CTI's) comprehensive audit of Delta Dental Insurance Company's (Delta Dental's) claims administration of the State of Montana (the State's) self insured Dental plans.

The information in this report is confidential and intended for the sole use of the Montana legislature, the State of Montana, Delta Dental, and CTI in their efforts to *serve the interests of the plan participants of the State of Montana Dental Plans*. This report is based on data and information provided to CTI by State of Montana and Delta Dental. CTI's compilations and findings rely upon the accuracy and completeness of that information and the samplings taken from it.

CTI is a firm specializing in audit and control of health plan claims administration. Accordingly, the statements made by CTI relate narrowly and specifically to the overall efficacy of Delta Dental's claims process and systems and to the accuracy and validity of State of Montana's paid claims during the audit period.

We conducted our audit in accordance with standards and procedures generally accepted and in common practice for Dental plan claims audits in the insurance industry of the United States.

No copies of this document may be made without the express, written consent of State of Montana, which commissioned its compilation.

CLAIM TECHNOLOGIES INCORPORATED
April 2014

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Key Findings

Comprehensive Claim Administration Audit of State of Montana Dental Plan by Delta Dental

Audit Period: January 1, 2013 to December 31, 2013

CTI's Comprehensive Audit of Delta Dental's claims administration of the State of Montana Dental Plans for the above-stated period included four components: 1) Operational Review; 2) Plan Documentation Review; 3) Electronic Screening; and 4) Random Sample Audit. Presented here are Key Findings from the audit as a whole. Supporting detail for the findings, conclusions, and recommendations herein can be found in the Specific Findings Report (provided separately).

The Random Sample Audit component included review of claims selected from those paid during the period of January 1, 2013 to December 31, 2013. Based on this sample, we compared Delta Dental's performance with that of other dental plans audited by CTI over the past 16 months. Of the six Key Performance Indicators¹ for which CTI has developed benchmarks to measure and monitor claims payment accuracy and administrative process quality Delta Dental's performance was above the median in two and below the median in four.

- Financial Accuracy, as demonstrated in the Random Sample Audit, was 99.07%, which is above the median as compared to other plans audited by CTI. Accurate Payment Frequency also was above the median of benchmark performance.
- Below median performance as demonstrated in the Random Sample Audit was the Key Performance Indicator of Accurate Processing Frequency. This indicator measures the overall accuracy of payment and procedures and was 93.52%, reflecting a 6.50% processing accuracy error rate. On an annual basis, this equates to over 3,645 claims processed with some type of error. Also below median performance were Documentation Accuracy—Frequency, Documentation Accuracy—Financial and Adjudication Proficiency. Two claims were dropped from the random sample and not included in calculation of performance results since they were inadequately documented. Inadequately documented claims are unable to be determined as being administered correctly.

The seventh Key Performance Indicator used by CTI, Claim Turnaround Time, is evaluated by looking at the distribution of turnaround time for claims in the audit sample; through this evaluation Delta Dental's claim turnaround time was very rapid, at one day.

In addition to its random sample audit, CTI employed its proprietary electronic screening system to screen 100% of the services processed by Delta Dental during the audit period. We found that certain limitations of the State of Montana Dental plans were not administered according to the plans' contract terms. It should be noted that CTI

¹ Financial Accuracy, Accurate Payment Frequency, Adjudication Proficiency, Accurate Processing Frequency, Documentation Accuracy Financial and Documentation Accuracy Frequency (operational Definitions for each indicator can be found in Exhibit A of this report.

intentionally sets its screening parameters conservatively to limit the number of false positives. Electronic screening results are reported for specific control risk categories. The dollar amounts associated with each category represent potential, not substantiated, overpayments.

Overpayment recovery, to the extent State of Montana wishes to pursue it, should be discussed with Delta Dental with specific recovery goals, timing and reporting agreed upon. CTI's comprehensive audit fee includes 10 hours of post-audit time to provide State of Montana with further assistance regarding any issues.

Delta Dental made every effort to cooperate with this audit and was able to provide CTI with the data and documentation that we requested.

Recommendations based on the foregoing are presented on page 11 of this report.

Comprehensive Audit Methodology

Audit Objectives

The specific objectives of CTI's comprehensive audit of Delta Dental's claims administration of the Dental benefits for persons insured through the State of Montana Dental Plans for the audit period were to:

- Evaluate the overall effectiveness and security of Delta Dental's claims payment and eligibility maintenance systems and processes;
- Determine if claims processed during the audit period were adjudicated according to the Plan Document/Summary Plan Description that govern the administration of claims and benefits;
- Determine if Delta Dental is fully and consistently performing services according to the in-force Administrative Services Agreement;
- Identify payment errors, including overpayments for possible recovery; and,
- Identify and address the causes of errors to address and prevent their recurrence in the future.

Audit Scope

The scope of the comprehensive audit included all State of Montana Dental claims paid or denied during the 12 months beginning January 1, 2013. Delta Dental paid or denied 56,257 claims (including adjustments) resulting in \$7,422,412 in total payment during this period.

Audit Methodology

To achieve the specific audit objectives stated above, CTI's audit included the following components:

I. Operational Review ➤ Operational Review Questionnaire Completed by Claims Administrator
II. Plan Documentation Review ➤ Evaluation of Plan Documents/Summary Plan Descriptions, Administrative Services Agreement ➤ Clarification of "Gray Areas" in Plan Documents/Summary Plan Descriptions ➤ Preparation of Plan Benefit Matrices for Use Audit
III. Electronic Screening ➤ Electronic Screening of 100% of Paid Claims for the audit period using ESAS® ➤ Problem Identification In Proven Control Risk Categories ➤ Identification of Recovery/Savings Potential ➤ Identification of Potentially Costly Procedural and System Problems
IV. Random Sample Audit ➤ Stratified Random Sample of 108 Dental Claims Paid or Denied <ul style="list-style-type: none">▪ Statistical Confidence level of 95%, with a 3% margin of error ➤ Error Identification by Type and Frequency ➤ Verification of Eligibility

Comprehensive Audit Results

Operational Review

Operational Review Scope

CTI conducted an operational review of Delta Dental to evaluate the systems, staffing and procedures related to claims administration, including eligibility maintenance, enrollment, customer service, appeals processing and fraud, waste and abuse control. Specifically, we reviewed these aspects of Delta Dental to observe any deficiencies that might materially affect their ability to control risk and pay claims on behalf of State of Montana.

Operational Review Methodology

CTI gathered information from Delta Dental through the use of a four-part questionnaire called the “Operational Review Questionnaire.” The questionnaire is modeled after the audit tool used by CPA firms when they conduct an SAS-70 (now the SSAE-16) audit of a service administrator. CTI modified the questionnaire to request more information than the SSAE-16 typically requires, but also to attain information specific to Delta Dental’s administration of State of Montana’s plans, rather than its overall book of business.

Finally, CTI used its proprietary electronic screening software to identify and select a targeted sample of cases from the claims processed by Delta Dental to test certain key processes that affect a small number of claims, but have a high payment potential. These included large dollar claims and claims subject to limitations or exclusions.

Operational Review Findings

CTI’s Operational Review concluded that:

- Delta Dental has adequate staffing to provide high levels of service accuracy for State of Montana and its members.
- Delta Dental has adequately documented workflow, training and procedures to provide consistently high levels of accuracy in the processing of claims and enrollment for the State of Montana members.
- Delta’s contract with the State of Montana includes performance guarantees. Delta’s self-reported results indicate all measures subject to guarantees were met during the audit period.
- Delta has appropriate levels of security and control with its claim funding and check issuance procedures.
- Delta has effective procedures for recovering overpayments from either participating dentists or members. Overpayments are recovered by withholding overpaid amounts from subsequent payments made to dentists or from members as appropriate. If Delta is responsible for an overpayment and funds

irretrievable, Delta will credit the State's account for the amount of the overpayment.

- Delta does not require multiple signatures for higher-dollar payment checks. Delta indicates that claims involving higher amounts typically require review by dental consultants, rather than claim examiners. CTI recommends that the State request a listing of payments that have been reviewed by dental consultants so it can determine whether this procedure provides an effective level of financial control, based on the State's requirements.
- Delta has excellent procedures for determining the existence of other coverage and validates coordination of benefits on a claim-by-claim basis. CTI notes that most administrators systematically require updates of COB information on a periodic basis, since claims for which other coverage may be available may not always include other carrier payment information.
- Delta provided a copy of the Complaint Report during the 12-month period of 1/1/2013 – 12/31/2013. A total of seven complaints were received for State enrollees and 17 days was the average total time to resolve the complaints. Delta's original claim decision was upheld in 71% of the appeals.
- Delta's Network Oversight and Compliance staff is well qualified and comprised of provider compliance analysts who are responsible for auditing financial and dental records. All current analysts possess either a bachelor's degree in criminal justice or a related field and several years of dental claims auditing experience.

Plan Documentation Review

Plan Documentation Review Objective, Scope and Methodology

CTI evaluated the Summary Plan Descriptions, Contract Amendments and Open Enrollment Guidelines that governed the claims administration of State of Montana's Delta Dental's plans in. CTI used these documents to develop a benefit matrix for the plans that maps each plan provision to the specific page of the Summary Plan Description. The benefit matrix served to inform our auditors and system analysts about the plans we were to audit.

Plan Documentation Review Findings

CTI observed that the State and Delta have agreed that diagnostic and preventive services will not accumulate to the plan member maximum benefits, even though this exception is not stated in plan documents. CTI recommends that State of Montana conform plan document language to claim administration when the handbook is reprinted.

Electronic Screening

Electronic Screening Objective and Scope

CTI performed electronic screening and analysis of 100 percent of each of the dental service lines that comprise a dental claim processed by Delta Dental during the 12 month period of January 1, 2013 – December 31, 2013). Delta Dental processed 56,257 claims (including adjustments) for 21,999 State of Montana claimants, representing 139,618 separate Dental service line items and resulting in \$7,422,412 in payment by the plan. To perform this screening, we used our proprietary ESAS® software. The objective of our electronic screening and analysis is to identify and quantify claim administration system problems that appear to be causing payment errors.

Methodology for Electronic Screening

CTI used ESAS® to screen each dental service line processed. ESAS® applies several hundred screening parameters to each service line to identify claims that may be paid in error. Any service line edited by ESAS® is considered “red-flagged,” meaning it has the potential for having been over- or under- paid, based on the screening parameters set into ESAS® and the claim data provided by the claim administrator.

To validate electronic screening findings, CTI selects targeted samples from the “red-flagged” service lines identified by ESAS® to test. Our experience has shown that this type of sampling is necessary in order to validate that the claim data provided was adequate to produce reliable screening results. While CTI is confident in the accuracy of our electronic screening results, it is important to note that the dollar amounts associated with the electronic screening results shown below represent potential, not actual, overpayments and process improvement opportunities. Additional testing of these claims by Delta Dental and State of Montana would be required to substantiate the findings and to provide the basis for remedial action planning.

Electronic Screening Findings

The findings by electronic screening category described below represent the areas where CTI recommends State of Montana investigate further with Delta Dental to learn if there is any recovery opportunity or if process improvements could produce future savings for State of Montana.

Candidates for Additional Testing	Potential Recovery/ Savings
Plan Limitations <ul style="list-style-type: none">○ Full Mouth X-rays○ Routine Cleanings	\$7,398

Random Sample Audit

Random Sample Audit Objective and Scope

The scope of our random sample audit included a stratified random sample of 108 paid or denied claims for employees and dependents with coverage under the State of Montana Dental plans. The statistical confidence level of the audit sample was 95% with a 3% margin of error. Each claim in the sample was reviewed by a CTI auditor to ensure that it conformed to the plan specifications, agreements, and negotiated discounts.

Random Sample Audit Methodology

Errors were cited when a claim selected in the random sample was paid or processed incorrectly, based on member eligibility or plan provisions defined in the Summary Plan Description or amendments to it. Payment errors were cited based on the documentation provided by the administrator for the sampled claim; errors remain even if they were later corrected, to allow for discussion between the State and Delta Dental about how to reduce the error rate and the need to re-work claims.

Additional observations (not errors) were cited when processes or payments beyond the scope of the sample were observed. CTI's audit system categorizes errors into one or more of six Key Performance Indicators, defined in Exhibit C of this report. The performance results within each Key Performance Indicator are used by CTI to measure and benchmark claim administration performance against the performance of other claim administrators audited by CTI.

Written dialogue occurred between CTI and Delta Dental to arrive at a conclusion on any observation made by CTI's team. After all relevant discussion, CTI's auditors concluded if an error had occurred and if so, which type. In the majority of errors cited, CTI and Delta Dental agreed on the error and the type of error. In some cases, agreement was not reached and Delta Dental and CTI "agreed to disagree." All errors and the discussion between CTI and Delta Dental were recorded in CTI's audit system. A preliminary Random Sample Audit report was reviewed and responded to by Delta Dental and their written response was taken into consideration before producing this final report.

Random Sample Audit Findings

When compared with the performance of other dental plan administrators conducted by CTI, Delta Dental's performance was and above the median in two of the six Key Performance Indicators and below the median in four of the six Key Performance Indicators for which CTI has developed benchmarks to measure and monitor claim payment accuracy and administrative process. Claim Turnaround, the seventh Key Performance Indicator used by CTI to evaluate claim administration proficiency, does not have a benchmark. Same day turnaround on claims is the fastest turnaround time that can be achieved, but is not necessarily the best turnaround time. The claim administrator should balance claim turnaround by handling all types of claims as efficiently as possible. Delta Dental's median claim turnaround time of Delta Dental

calendar days was one day. Delta Dental's administrative performance across all seven Key Performance Indicators is reflected in the following chart:

Key Performance Measures	Administrative Performance by Quartile			
	● Bottom Quartile	○ 2 nd Quartile	○ 3 rd Quartile	● Top Quartile
Documentation Accuracy -- Financial	●			
Documentation Accuracy -- Frequency	●			
Financial Accuracy			○	
Accurate Payment Frequency			○	
Adjudication Proficiency		○		
Accurate Processing Frequency		○		
Claim Turnaround Time (From Date Received to Date Processed)	Median Turnaround Time Optimal at 1 day.			

For more specific information on how Delta Dental's performance in this audit compared to other audits performed by CTI, see the "Box and Whiskers" charts in Exhibit B. Additionally, the charts in Exhibit B. provide statistical process control tools and information to determine materiality, underlying causes, and corrective actions for the problems and improvement opportunities identified through the random sample audit.

Financial Accuracy of 99.07%, when imputed to the universe of approximately \$7.5 million in paid claims during the one-year random sample audit period, indicates Delta Dental made errors totaling approximately \$70,000 during the random sample audit period. Of the financial errors cited in our random sample of Dental claims, none were overpayments and all were underpayments. While overpayments represent opportunity for initiating recovery and saving money for the State of Montana plan, underpayments also are of concern. Each underpaid claim is likely to result in an appeal from a provider or a State of Montana employee with a corresponding claims adjustment that may increase administrative costs as a result of "double-handling" claims. Fifty percent of the adjudication errors we cited related to Delta Dental's improper application of provisions specified in State of Montana's benefit plan documents. The types and frequency of adjudication errors cited during the random sample audit are indicated below:

Error Category	Number of Errors Cited
Should Have Been Pended for Additional Information	2
Dollar Limits Not Applied	1
Denied Eligible Expense	1
Total Number of Financial Errors in Delta Dental Claim Sample	4

Summary of Recommendations from the Comprehensive Audit

Based on the findings of our comprehensive claim administration audit of Delta Dental, we recommend the following next steps:

1. Discuss with Delta Dental an approach to conducting further focused analysis of the errors identified through electronic screening in the category of payments of limited services, to determine if overpayment recovery is possible and to recommend improvements they can make to reduce or eliminate similar errors. For the issues identified by electronic screening, claim detail can be prepared by CTI for Delta Dental to use in this analysis.
2. Meet with Delta Dental to discuss audit findings, with agenda, to focus on necessary steps to improve Documentation Accuracy—Financial and Documentation Accuracy—Frequency as well as Accurate Processing Frequency. To facilitate this discussion, the State should ask Delta Dental to review each of the errors identified by the random sample audit and determine if changes in procedures or system changes should be made to reduce or eliminate future errors of a similar nature.
3. Continue to conduct sequential audits to ensure performance guarantees are met.

We understand that State of Montana will review these recommendations to determine the subject of immediate action. Where State of Montana determines that our assistance would be beneficial in implementing or performing any of the required tasks, we will be pleased to provide cost estimates for these services on an hourly or fixed-fee project basis. Included in our Comprehensive audit specifications are 10 hours for post-audit follow-up activities on issues identified by the audit.

We have considered it a privilege to have worked for and with State of Montana's staff in these important endeavors and would welcome any opportunity to assist you in achieving your future objectives. Thank you again for choosing CTI.

CLAIM TECHNOLOGIES INCORPORATED
April 2014

Exhibits

- A. Performance Measurements and Benchmarking**
- B. Prioritization of Errors and Savings Opportunities**
- C. Key Performance Indicators Operational Definitions**

Exhibit A.

Performance Measurement and Benchmarking

Based on the 100 most recent claim administration audits CTI has performed, the following “Box and Whiskers Charts” show Delta Dental’s claim administration performance for each Key Performance Indicator as compared to that for other plans audited by CTI. Each chart contains the following information:

- Delta Dental’s Performance
- Benchmark Performance
- Lowest Performance
- Performance levels in quartiles with the 4th Quartile representing the performance of the 25 plans with the best performance and the 1st Quartile representing the 25 plans with the lowest performance
- Performance relative to the Median level or the reported level at which 50 of the plans audited by CTI were reported to be better and 50 were reported to be worse.

Chart 1. – Financial Accuracy

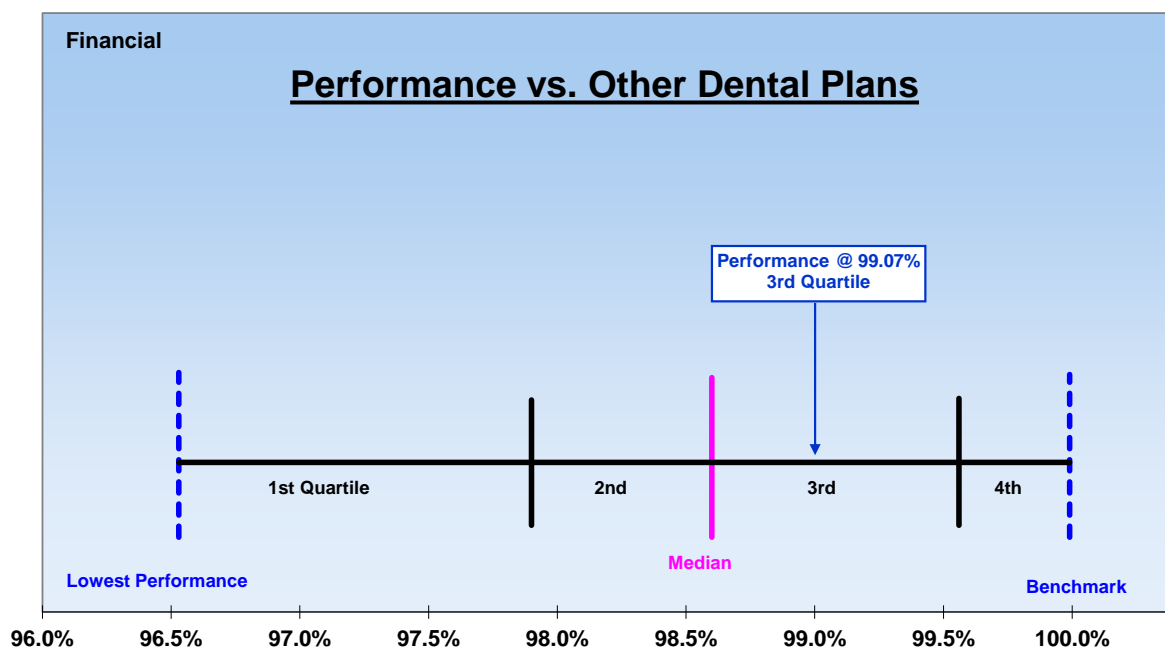


Chart 2. – Accurate Payment Frequency

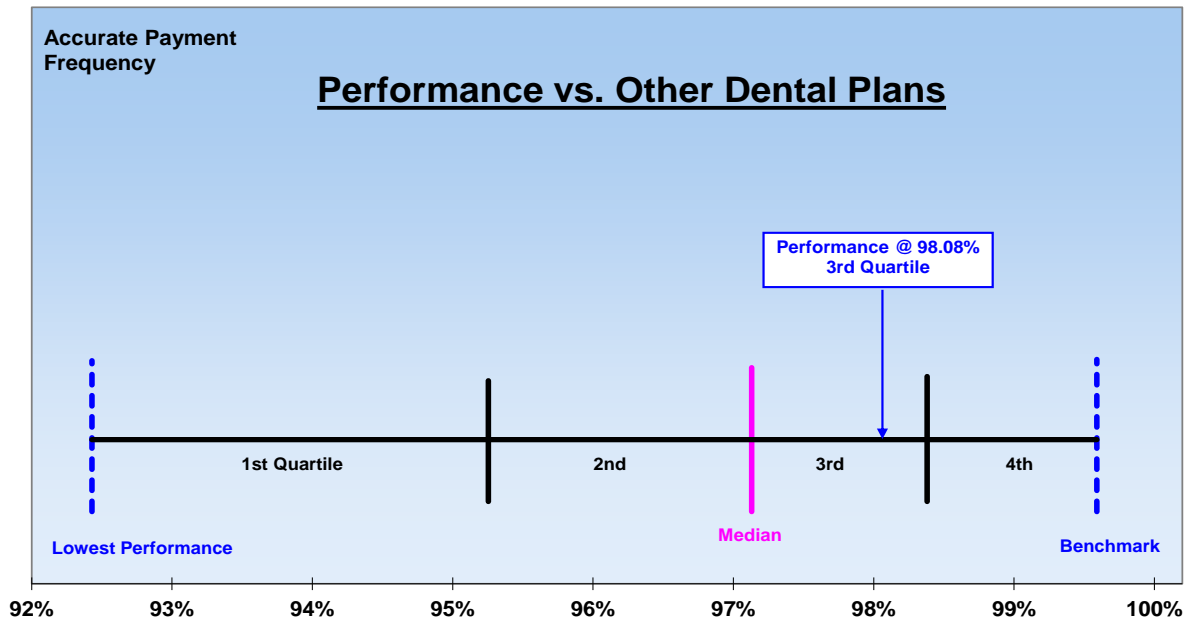


Chart 3. – Adjudication Proficiency

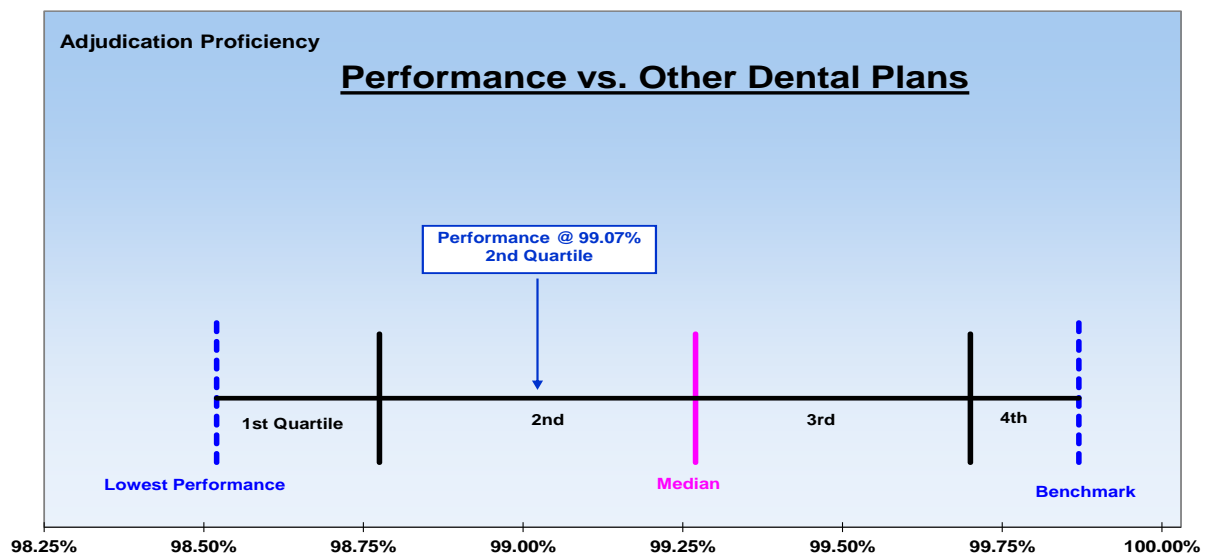


Chart 4. – Accurate Processing Frequency

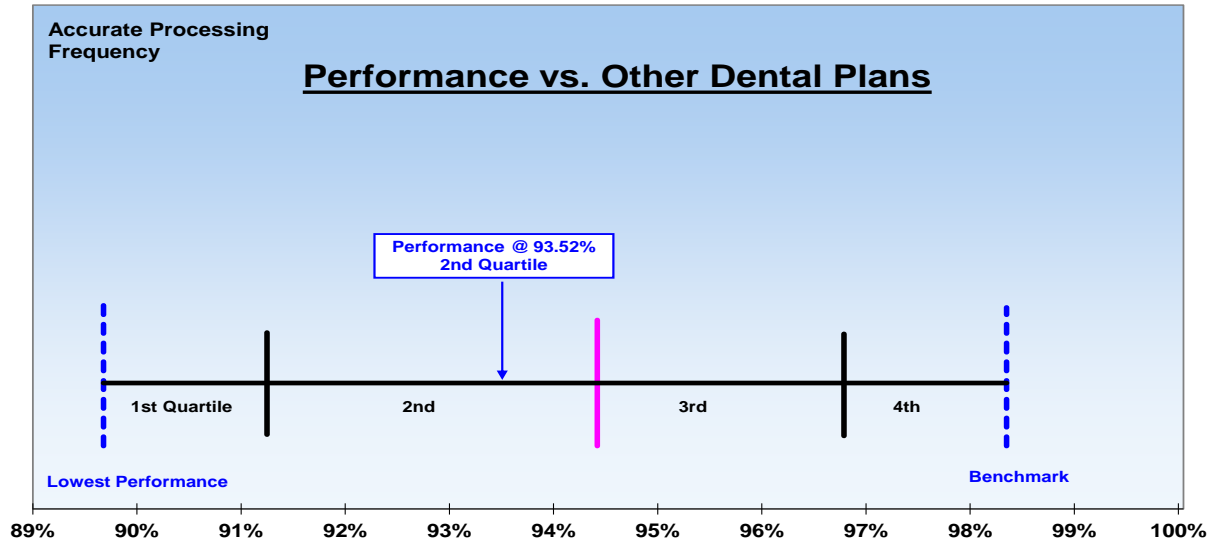


Chart 5. – Documentation Accuracy Financial

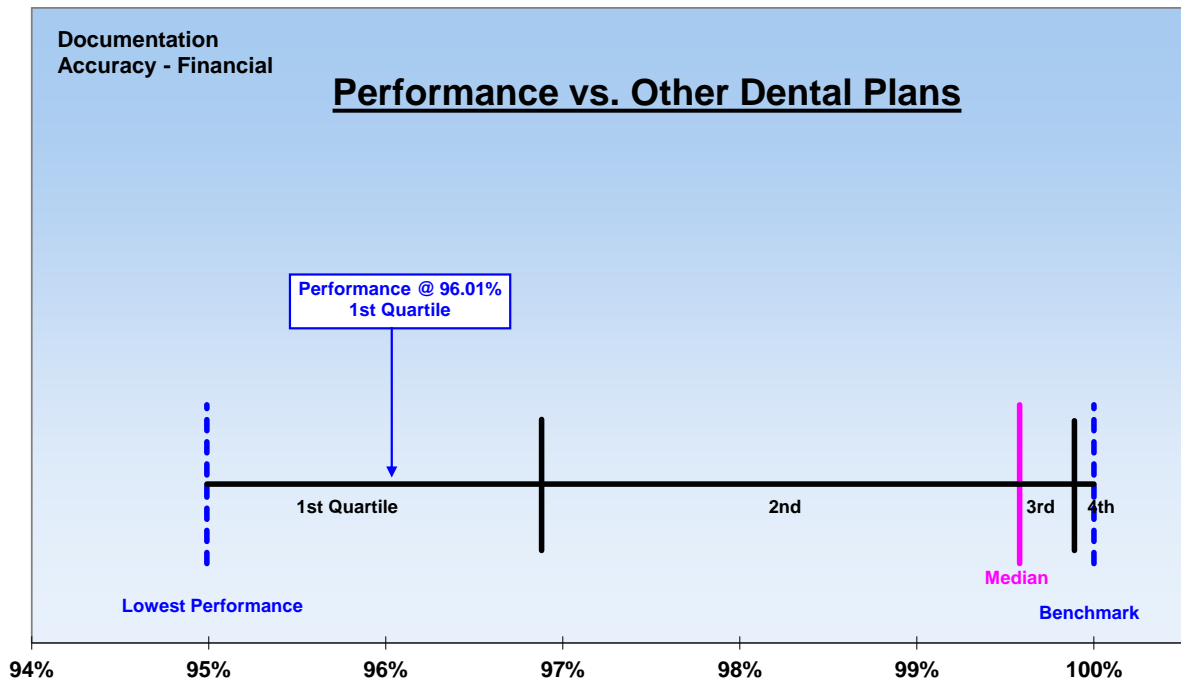


Chart 6. Documentation Accuracy Frequency

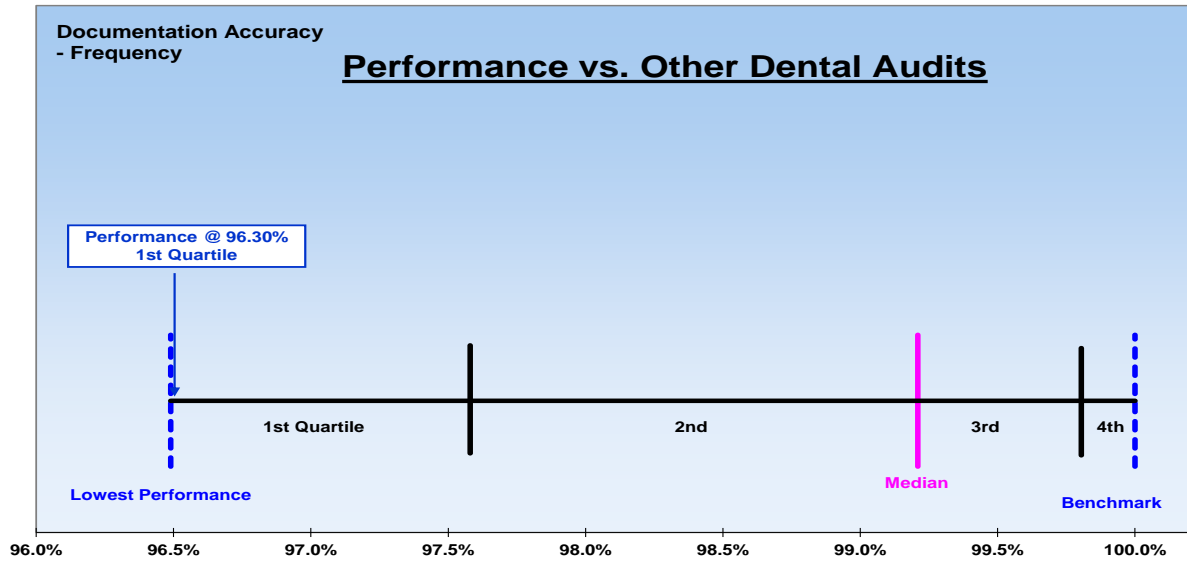


Chart 7. Claim Turnaround

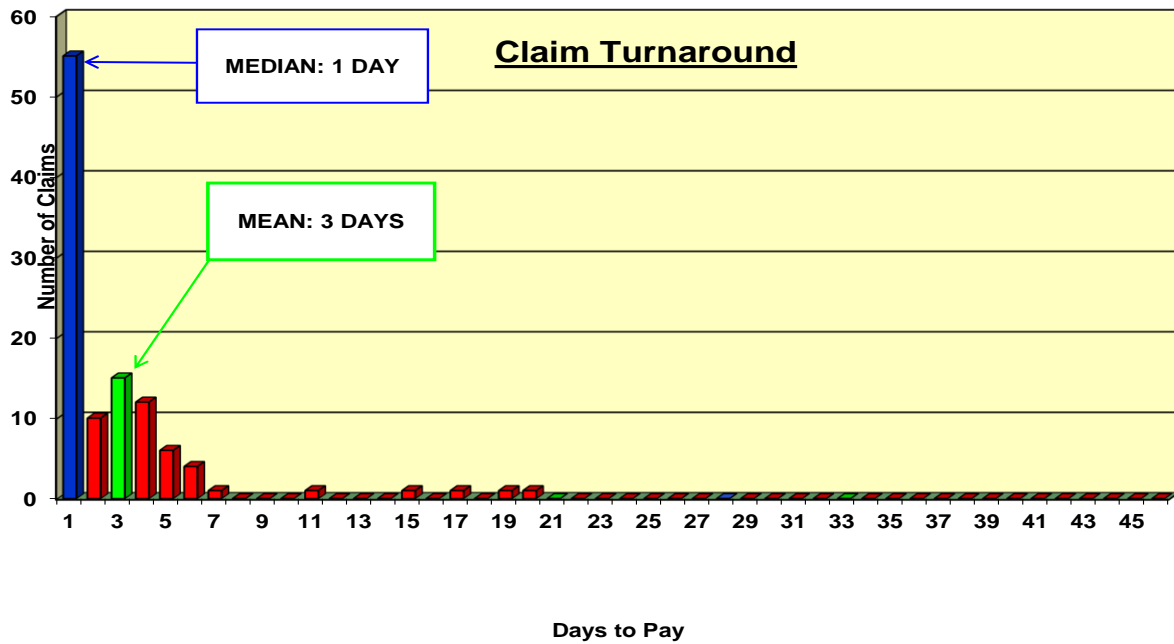


Exhibit B.

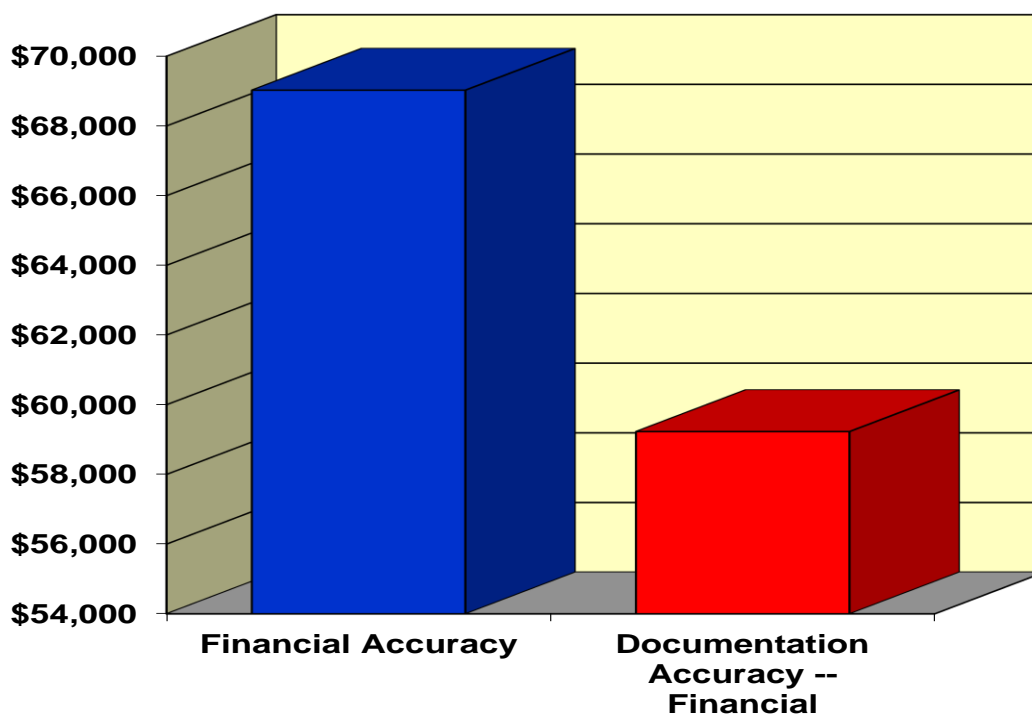
Prioritization of Process Improvement Opportunities

Derived from the Random Sample Audit data, the following charts provide statistically based insights to assist in prioritizing improvement and/or recovery opportunities based on savings and service impact; and in pinpointing problem causes.

The following Pareto chart ranks in order of materiality the potential annual financial impact achievable by improving key process performance from the level demonstrated in the audit to the benchmark.

Chart 1.

Potential Delta Dental Improvement – Financial
\$7,422,412 Annual Paid Dental Claims for State of Montana



The following pie charts (Charts 2-5) show the frequency of errors made by Delta Dental by type of error so that remedial actions can be taken to prevent their recurrence in the future.

Chart 2.

**Delta Dental Overall Processing Accuracy
Based on Random Sample**

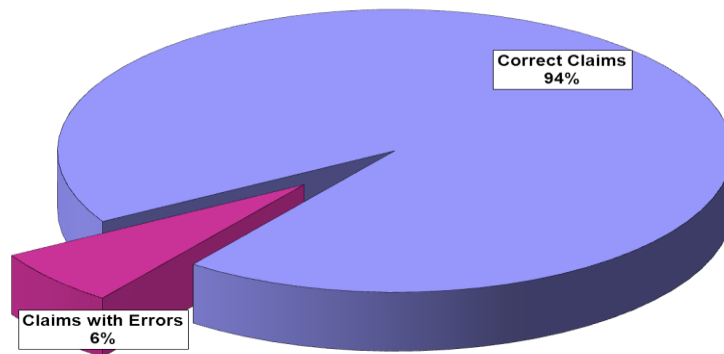


Chart 3

**Delta Dental Frequency of Financial Errors by Type
Based on Random Sample**

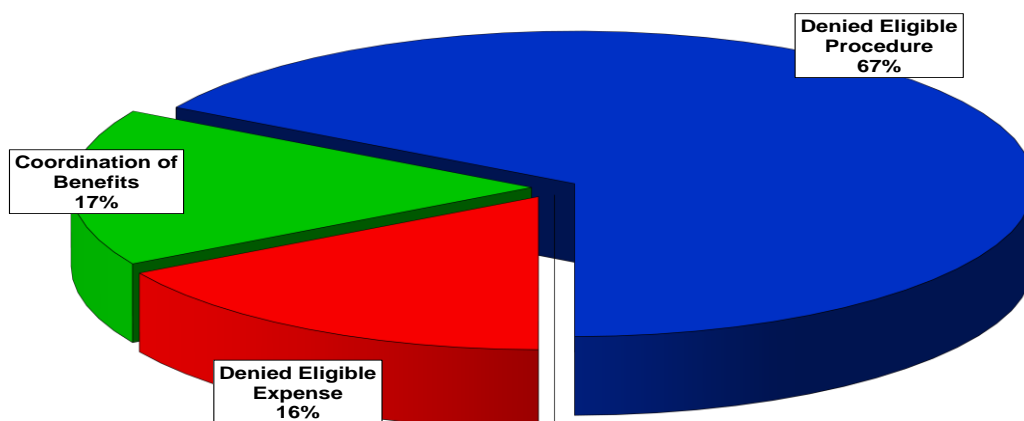


Chart 4.

**Delta Dental Frequency of Adjudication Errors By Type
Based on Random Sample**

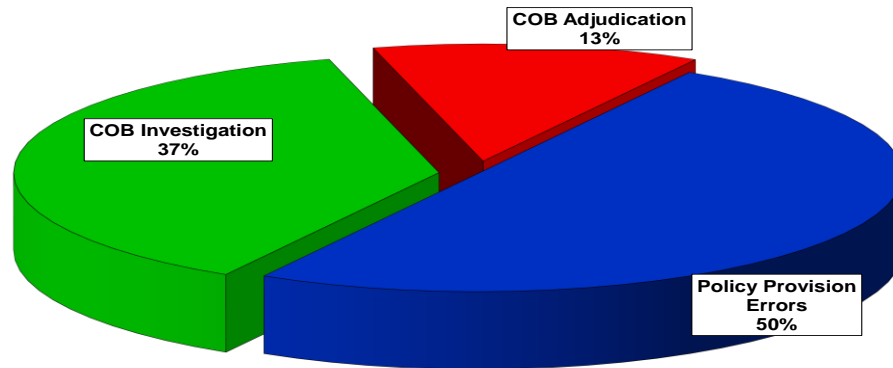


Chart 5.

**Delta Dental Frequency of Policy Provision Errors By Type
Based on Random Sample**

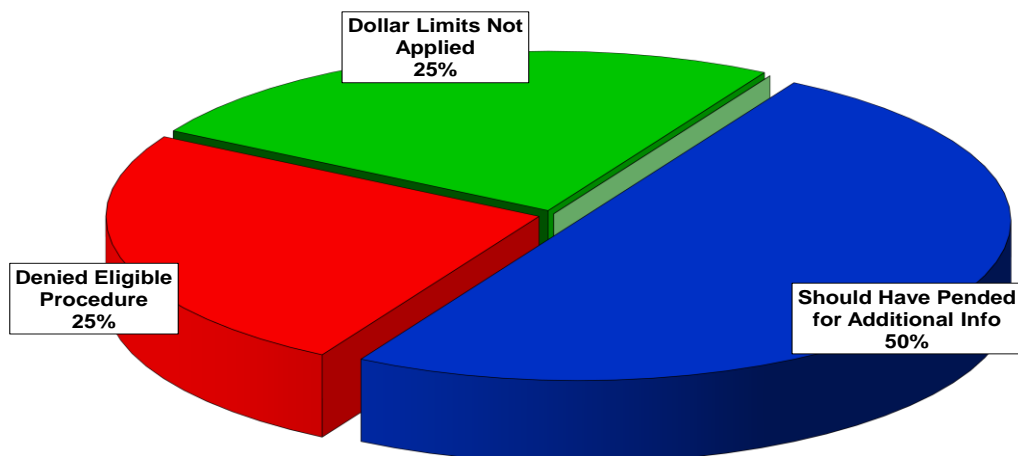


Exhibit C.

Key Performance Indicators and Operational Definitions

CTI Key Performance Indicators for Payment Accuracy and Proficiency

Financial Accuracy - compares the total dollars associated with correct claim payments to the total dollars of correct claim payments that should have been made.
Accurate Payment Frequency - compares the number of bills paid correctly to the total number of bills paid.
Documentation Accuracy Financial - compares the number of dollars processed with documentation adequate to substantiate payment or denial to the total number of dollars processed.
Claim Turnaround - is the number of calendar days required to pay a claim -- from the date the claim is received by the administrator to the date a payment or denial is mailed.

CTI Key Performance Indicators for Procedural Accuracy and Proficiency*

Adjudication Proficiency - compares the number of correct adjudication decisions made to the total number of adjudication decisions required.
Documentation Accuracy Frequency - compares the number of claims processed with documentation adequate to substantiate payment or denial to the total number of claims processed.
Accurate Processing Frequency - compares the number of bills processed without errors of any type (financial or non-financial) to the total number of bills processed.

** These measures may or may not have caused payment errors, but will be indicators of the type and frequency of procedural deficiencies that could result in payment errors.*

COMPREHENSIVE CLAIMS ADMINISTRATION AUDIT

SPECIFIC FINDINGS REPORT

State of Montana Dental Plans

Administered by: Delta Dental

Audit Period: January 1, 2013 to December 31, 2013

Presented to:

State of Montana

April 16, 2014

Private and Confidential

Presented by:

Claim Technologies Incorporated

Preface

The Specific Findings Report is a compilation of the detailed information, findings, and conclusions drawn from Claim Technologies Incorporated's ("CTI's") comprehensive audit of Delta Dental's claims administration of the State of Montana self-insured dental plans. The statistics, observations, and findings herein constitute the basis for the analysis and recommendations presented separately in the accompanying Executive Summary.

The information herein is confidential and intended for the sole use of the Montana legislature, the State of Montana, Delta Dental, and CTI in their efforts to serve the interests of the plan participants of the State of Montana dental plans.

This report is based on data and information provided to CTI by State of Montana and Delta Dental. CTI's compilations and findings herein rely upon the accuracy and completeness of that information and the samplings taken from it.

CTI is not a Certified Public Accounting firm, it is a firm specializing in audit and control of health plan claims administration. Accordingly, the statements made by CTI relate narrowly and specifically to the overall efficacy of Delta Dental's claims process and systems and to the accuracy and validity of State of Montana's paid claims during the audit period.

No copies of this document may be made without the expressed, written consent of State of Montana who commissioned its compilation.

CLAIM TECHNOLOGIES INCORPORATED
April 2014

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Introduction

CTI performed a comprehensive audit of Delta Dental's claims administration of the State of Montana dental plans for the 12-month period of January 1, 2013 to December 31, 2013. We conducted our audit in accordance with standards and procedures generally accepted and in common practice for dental plan claims audits in the insurance industry of the United States. We planned and performed our audit to obtain reasonable assurances that claims were adjudicated according to the plan benefits; and to form our opinion as to the overall efficacy of Delta Dental's financial controls, accuracy and validation of paid claims. The audit included the following components:

CTI Comprehensive Audit

I. <u>Operational Review</u>	Pre-Audit Questionnaire with In-Field Examination and Testing <ul style="list-style-type: none">• Claims Administrator Information• Claims Administrator Claim Fund Account• Administrator Claim Adjudication• Administrator Eligibility Maintenance Procedures• HIPAA Compliance
II. <u>Plan Documentation Review</u>	Evaluation of Plan Documentation <ul style="list-style-type: none">• Gray Area Clarification
III. <u>Electronic Screening</u> [screening encompassed 100% of Paid Claims during the audit period and the preceding 12 months]	Problem Identification and Substantive Testing in Proven Control Risk Categories <ul style="list-style-type: none">• Identification of Savings Opportunity and Potential Overpayments• Immediate Remedy of Costly Leaks and System Problems
IV. <u>Random Sample Audit</u> [Sample Confidence @ 95% +/- 3%]	Measurement and Comparison of Administrator Performance <ul style="list-style-type: none">• Performance Metrics for Key Indicators• Benchmarking vs. Best-in-Practice• Problem Identification and Prioritization• Error Identification by Type and Frequency• Statistically-Based Remedial Action Plans• Systematic Monitoring and Control

Audit Process Overview

CTI's Comprehensive Audit is designed to measure and facilitate continuous quality improvement of the processes of claims administration. We audit claims administration performance both electronically through screening and analysis of 100% of the claims data, and statistically through an audit of a stratified random sample of claims

processed during the audit period specified. Statistics regarding the population of claims and amount paid by the Plan during the 12 month audit period are shown below:

Total Paid Amount	\$7,422,412
Total Number of Claims Paid/Denied	56,257

Below is an overview of the systems used and protocols followed in completing this comprehensive audit.

Audit Planning and Protocol

Audit Process and Procedures Reviewed and Agreed Upon: CTI's audit process and timeline are reviewed in advance with the Plan Sponsor who commissioned the audit and then with the Claim Administrator who will be audited. The Administrator is informed that although agreement may not always be reached on the findings reported, it is CTI's policy always to present the Administrator's views in addition to its own.

Pre-Audit Preparation

- **Operational Review:** CTI's Operational Review process utilizes a detailed four-part Operational Review Questionnaire that is sent to and completed by the Claim Administrator. The Administrator's responses and supporting documentation are used to evaluate systems, staffing, and procedures related to claims administration including enrollment and overpayment recovery. CTI verifies the responses of the Administrator on key operational processes by utilizing its electronic screening system to identify a small number of candidate cases that are exemplary of that process to test while we are in the field. CTI also uses the questionnaire responses to prepare for its Random Sample Audit and Electronic Screening.
- **Plan Documentation Review:** Preparation for the Comprehensive Audit includes CTI's in-depth evaluation of all relevant plan documentation including the Member Handbook and amendments, the Administrative Service Agreement. The provisions of these documents constitute the specifications against which claim payment accuracy and process quality are audited.
- **Random Sample Selection:** Using proprietary methods and software, CTI constructs a stratified random sample, which supports a 95% confidence level with a bound of +/- 3%.
- **Initial Electronic Screening:** CTI's proprietary screening software, ESAS®, produces reports of claims "Red Flagged" by Control Risk Category. Control Risk Categories are categories of claims that have been proven through experience to have a higher risk of payment error in that they may require more complex adjudication processes.

Targeted Sampling

Targeted samples are selected from the most material categories of ESAS®. CTI prepares and sends questionnaires called Substantive Testing Questionnaires for each sampled item to the Claim Administrator. The final ESAS® screening results are presented to the Plan Sponsor in the Electronic Screening section of this report. These results are intended for use in determining if any category has sufficient materiality or control risk to warrant further focused review or discussion on recovery/savings potential.

Random Sample Audit

Each claim selected in the Random Sample Audit is reviewed by a CTI auditor with respect to the Plan Document, agreements and contracts that govern the way that claim should be processed. Each error observed and any Additional Observation made is recorded and the Administrator is given ample opportunity to rebut the error. The results of the Random Sample Audit are presented in the Random Sample Audit section of this report.

Review of Audit Draft Reports

Preliminary Working Drafts of the Electronic Screening and Random Sample Audit sections of this report are sent to the Claim Administrator to allow a final opportunity for rebuttal of errors. The Administrator's responses to the Preliminary Working Drafts are taken into consideration before completion of the final reports and are included in the Exhibits of those report sections.

Analysis, Quantification, and Recommendations

The information and details resulting from the systems and protocols described previously are presented in this Specific Findings Report. Separately in the Executive Summary the results are summarized and represented using statistical analysis and continuous quality improvement tools developed by CTI for this purpose. Through this analysis, improvement opportunities are prioritized and recovery and remedial action recommendations are made for the consideration of the plan sponsor and the Claim Administrator. The Executive Summary is provided to the plan sponsor upon completion of the audit, but we do not provide a copy to the Claim Administrator unless so instructed.

PLAN DOCUMENTATION REVIEW

State of Montana Dental Plans

Administered by:

Delta Dental

Audit Period: January 1, 2013 to December 31, 2013

Prepared: April 16, 2014

Private and Confidential

PLAN DOCUMENTATION REVIEW

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Overview

Plan Documentation Review Objectives

The objectives of the Plan Documentation Review are to evaluate the plan documentation that governs the administration of State of Montana self-insured dental plans and to create knowledge on the part of our auditors about the plan(s) that they will be auditing through the electronic screening and random sample audit phases of this comprehensive audit. The Plan Documentation Review results in the development of a Benefit Matrix for each plan to be audited, the matrix is used by CTI's auditors in the Comprehensive Audit process.

Plan Documentation Review Scope

CTI auditors evaluate the following documentation that is in force during the audit period for the plan(s) that we are to audit:

- Plan Documents/ Summary Plan Descriptions and all amendments,
- Reinsurance agreement (if applicable),
- Administrative Services Agreement.

Plan Documentation Review Methodology

CTI obtains a copy of the plan documentation from both the claim administrator and the plan sponsor. We compare the documents from the two sources to ensure that they match in every way.

Using a tool that we have developed for this purpose called the "Benefit Matrix," CTI performs and documents the results of an in-depth review of the Plan Documents/ Summary Plan descriptions and amendments, noting any inconsistencies and missing provisions. The Benefit Matrix includes all plan provisions most frequently encountered in CTI's audits of dental plans. CTI creates a Benefit Matrix for each plan being audited.

CTI obtains clarification from the plan sponsor to any inconsistencies and missing provisions in the Plan Documents/Summary Plan descriptions and amendments observed through the process of completing the Benefit Matrix. We refer to the items requiring clarification as "Gray Areas." The plan sponsor's clarification is incorporated into the Benefit Matrix and is tested as are all other provisions of the plan(s) through the Electronic Screening and Analysis and the Random Sample Audit.

The provisions of the plan documentation constitute the specifications against which claim payment accuracy and process quality are audited by CTI.

The following section describes CTI's observations regarding the plan documentation. Gray area clarifications that CTI requested as a part of this audit are shown in Exhibit A.

Plan Documentation Review Findings

After CTI's review of the State of Montana Dental plan documents and as observed through the course of the random sample audit CTI discovered that the State has authorized Delta Dental to waive diagnostic and preventive services from accumulating to the member plan maximum.

Plan Documentation Review Recommendations

The State of Montana and Delta Dental should review and discuss this situation and revise the plan documents accordingly.

OPERATIONAL REVIEW REPORT

State of Montana

Administered by:

Delta Dental

Audit Period: January 1, 2013 – December 31, 2013

Prepared: April 2, 2014

OPERATIONAL REVIEW REPORT

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A. Operational Review Questionnaire with Response	A-1

Overview

Operational Review Objectives

The objectives of the Operational Review are to evaluate Delta Dental's (Delta's) systems, staffing, and procedures related to claims administration, including enrollment and overpayment recovery, of the State of Montana dental plan. The Operational Review also is used in support of our random sample audit and electronic screening activities.

Operational Review Scope

The scope of our Operational Review is to evaluate the systems, staffing and procedures related to claims administration including eligibility maintenance, enrollment, customer service, appeals processing and fraud, waste and abuse control. Specifically we reviewed these aspects of Delta to observe any deficiencies that might materially affect their ability to control risk and pay claims on behalf of State. Information and supporting documentation or reports are gathered through the use of an Operational Review Questionnaire. The operational functions verified and/or assessed through the Questionnaire include:

- Claims Administrator Information
 - Insurance and bonding of the Claim Administrator
 - Conflicts of interest
 - Internal audit
 - Financial reporting
 - Business continuity planning
 - Claims payment system and coding protocols
 - Security of data and systems
 - Staffing
- Administrator's Claim Fund Account
 - Claim funding mechanism
 - Check processing and security
- Administrator's Claim Adjudication and Eligibility Maintenance Procedures
 - Exception claims adjudication procedures
 - Eligibility maintenance and investigation procedures
 - Overpayment recovery
 - Network utilization
 - Appeals processing
- HIPAA Compliance

CTI utilizes its proprietary Electronic Screening and Analysis (ESAS®) software to identify candidate cases to test the operational processes related to claim adjudication and eligibility maintenance.

Operational Review Methodology

CTI gathered information from Delta through the use of a four-part questionnaire called the “Operational Review Questionnaire”. The questionnaire is modeled after the audit tool used by CPA firms when they conduct a SSAE-16 audit of a service administrator. CTI modified the questionnaire to request more information than the SSAE-16 typically requires, but also to attain information specific to Delta’s administration of the State dental plan, rather than its overall book of business.

CTI’s audit staff reviewed the responses and the supporting documentation and reports and prepared follow-up questions presented to Delta.

Delta’s claim adjudication and eligibility maintenance procedures as described in its responses to that section of the Operational Review Questionnaire were tested through a focused audit of a sample of candidate cases identified by CTI’s proprietary ESAS® software. A CTI auditor set up parameters in ESAS® specific to the procedures described in Delta’s questionnaire responses. The focused audit was conducted using a survey tool called a “Substantive Testing Questionnaire” that was sent to Delta for completion on each selected case. Responses from Delta were used to validate that the administrative procedures described in their response to the Operational Review Questionnaire were being followed during the audit period.

Findings and Recommendations

Claims Administrator Information (Part A of questionnaire)

Part A of the Questionnaire is designed to obtain Claims Administrator Information including background information on the administrator, financial reports, types and levels of insurance protection, dedicated staffing, claims administration systems and software, disclosure of fees and commissions, performance standards and internal audit practices. CTI offers the following observations relative to this portion of the Operational Review:

- Delta has adequate staffing and systems to provide high levels of service accuracy to the insureds of the State.
- Delta has complied with the standards of the American Institute of Certified Public Accounts (AICPA) through issuance of a Statement on Standards for Attestation Engagements (SSAE) No. 16, Reporting on Controls at a Service Organization, which replaces the prior SAS 70 Report. Under SSAE 16, Delta is required to provide its own description of its system, which the service auditor validates. According to Delta’s auditor, Armanino, the controls related to the control objectives stated in the description were suitably designed to provide reasonable assurance that the control objectives would be achieved if operated effectively. The controls tested showed no relevant exceptions.

- Pertinent insurance coverage for crime, E & O and fidelity bond were provided and display adequate coverage limits.
- Delta's self-reported performance for measures subject to guarantees indicates that goals were met for each measure and that no penalty payments are due to the State
- While Delta has dedicated account management staff serving the State, it does not have dedicated staff providing claim or customer service for State.

Administrator's Claim Fund Account (Part B of questionnaire)

Part B of the questionnaire is designed to obtain information specific to controls and procedures related to claim checks including claim funding, fund reconciliation, handling of refunds and returned checks, large check approval, security, disposition of stale checks and appropriate audit trail reports. CTI offers the following observations relative to this portion of the Operational Review:

- Delta has appropriate levels of security and control within its claim funding and checks issuance procedures to protect State's interests and to ensure that transactions are performed by only authorized personnel.
- Delta has effective procedures for recovering overpayments from either participating dentists or members. Overpayments are recovered by withholding overpaid amounts from subsequent payments made to dentists or from members as appropriate. If Delta is responsible for an overpayment and funds irretrievable, Delta will credit the State's account for the amount of the overpayment.
- Delta does not require multiple signatures for higher-dollar payment checks. Delta indicates that claims involving higher amounts typically require review by dental consultants, rather than claim examiners. CTI recommends that the State request a listing of payments that have been reviewed by dental consultants so it can determine whether this procedure provides an effective level of financial control, based on the State's requirements.
- Delta turns stale checks over to the states under escheatment laws for abandoned property.

Administrator's Claim Adjudication and Eligibility Maintenance Procedures (Part C of questionnaire)

Part C of the questionnaire is designed to obtain information specific to the controls and procedures used by the administrator related to enrollment, eligibility maintenance and processing of claims. Gathered in this questionnaire is information regarding claims processing and eligibility maintenance workflow, preferred provider organizations,

pursuit of claim reimbursements from third parties, dentist fee allowance (UCR) data source, and coding schemes used for diagnosis and procedure codes.

CTI tests the administrator's controls and procedures by selecting specific claim cases processed during the audit period. For this audit a total of 10 candidate cases were selected and Substantive Testing Questionnaires were prepared for each and sent to Delta for completion.

The population of claims electronically screened is defined as all State Dental Plan claims paid, or denied, including adjustments, voids and reversals during the prescribed audit period regardless of the incurred date of the claim. The audit period was January 1, 2013 – December 31, 2013. The universe of Paid Claims electronically screened was:

Total Paid Amount	\$7,422,412
Total Number of Claims Paid/Denied	56,257

CTI offers the following observations from its analysis of Delta's responses to this section of the Operational Review Questionnaire and from the responses gathered through our Substantive Testing Questionnaires:

- Delta has adequately documented training, workflow, procedures and systems to provide high levels of accuracy in the processing of claims.
- Delta validates coordination of benefits on a claim-by-claim basis. CTI notes that most administrators systematically require updates of COB information on a periodic basis, since claims for which other coverage may be available may not always include other carrier payment information.
- Delta's self-reported COB savings for 2013 were \$90,917 or 1.21% of paid claims.
- Delta does not actively subrogate dental claims.
- Delta reported overall, 60% of claims are submitted electronically.
- Delta does not have a minimum threshold for overpayment as Delta has the ability to offset overpayment amounts by withholding from future payments.
- Delta reports overall that 97.2% of claims come from participating providers.
- Delta provided a copy of the Complaint Report during the 12-month period of 1/1/2013 – 12/31/2013. A total of seven complaints were received for State enrollees and 17 days was the average total time to resolve the complaints. Delta's original claim decision was upheld in 71% of the appeals.
- Delta's Network Oversight and Compliance staff is comprised of provider compliance analysts who are responsible for auditing financial and dental records. All current analysts possess either a bachelor's degree in criminal justice or a related field and several years of dental claims auditing experience.

Part D – HIPAA Compliance

Questionnaire Part D is designed to obtain information specific to the process the administrator has implemented in order to become compliant with the HIPAA regulations. The objective of this questionnaire segment is to determine if the administrator is aware of the HIPAA regulations and is compliant.

- Delta has appropriate levels of security and controls in place to protect State plan records and data and is compliant with HIPAA requirements.
- Delta is compliant with the Electronic Data Interchange requirements of HIPAA.
- No breaches of privacy and security were reported for the State's members.

Exhibit

A. Operational Review Questionnaire and Responses



Operational Review Questionnaire
for
Comprehensive Claim Administration Audit
of
The State of Montana Dental Benefit Plan
Delta Dental

- **Part A – Claims Administrator Information**
- **Part B – Administrator’s Claim Fund Account**
- **Part C – Administrator’s Claim Adjudication and Eligibility Maintenance Procedures**
- **Part D – HIPAA Requirements**

Date Sent: December 5, 2013

Part A: CLAIMS ADMINISTRATOR INFORMATION

1. **Name of Administrator:** Delta Dental Insurance Company (Delta Dental)

2. **Number of years serving this/ these plans:**

☒ 5 or less years ☐ 5-10 years ☐ 10 years or more

**State of Montana's Delta Dental plan was effective January 1, 2013.*

3. **Number of clients for which you process dental claims:**

☐ Less than 10 ☐ 10 to 50 ☒ 50 or more

4. **Employee Crime Policy/ Fidelity Bond**

a. **Please provide the declarations page of the Crime Policy (or Fidelity Bond) for your employees. Copy provided?** ☒ Yes
☐ No

Provided as exhibit Declarations Page Fidelity Insurance Bond (Crime Policy).

b. **If not provided, please explain:**

c. **Are your employees subject to background checks to screen for felony convictions?** ☒ Yes
☐ No

5. **Employee Confidentiality:**

a. **Are your employees required to sign agreements that restrict them from disclosing confidential information relating to the insureds covered by this plan?** ☒ Yes
☐ No

6. **Errors & Omissions Policy:**

a. **Please provide a declarations page for your Errors & Omissions Policy. Copy provided?** ☒ Yes
☐ No

Provided as exhibit Declarations Page Errors & Omissions.

b. **If not provided, please explain:**

7. **Other Compensation:**

a. **Are all agreements for fees or commissions to all parties** ☒ Yes

receiving compensation from these plans known to the client? ☐ Yes ☐ No

8. Conflict of Interest:

- a. Does your firm or do any officers of your firm have any interest in any organizations which offer services to this plan or its participants? ☐ Yes ☒ No
- b. If Yes, please identify parties and provide brief explanation:

9. Performance Standards

- a. Are there performance standards in place for the administration of this client's eligibility (including ID card issuance), claim adjudication, customer service? ☒ Yes ☐ No

*State's Performance Guarantees include a claims and customer service category. Eligibility is not listed; however, our standard is to issue all ID cards within 10 business days.

- b. If Yes, please provide a copy of standards. Copy provided? ☒ Yes ☐ No

Provided as *State of Montana 2013 Performance Guarantees*.

- c. If Yes to a. above, provide a copy of the report or reports of your performance during the audit period. If the audit period spans more than one performance guarantee period, provide reports from both periods. Copy provided? ☐ Yes ☒ No

Performance Guarantees are measured monthly but reported annually. The State became effective January 1, 2013. The 2013 annual PG report will be released the end of the first quarter of 2014.

- d. If Yes to a. above, and if you did not perform at or above minimum levels of performance, has a credit for the period or periods been issued to the client? ☐ Yes ☐ No

Not applicable

- e. If Yes to d. above, how much was the credit and in what form and when was it issued to the client?

10. Financial Report:

- a. Please provide a copy of your most recent audited financial report. Copy provided? ☒ Yes
☐ No

Provided as exhibit *Delta Dental 2012 Audited Financial Statement*.

- b. If not provided, please explain:

11. SSAE- 16 Audit:

- a. Has an SSAE – 16 audit been performed on your organization in the past 2 years? ☒ Yes
☐ No
- b. If Yes, please provide a copy of the SSAE-16 audit report. If not provided, please explain.

Provided as exhibit *SSAE No 16 Report*.

12. Additional Documents Required:

Please provide a copy of each of the following documents:

- a. The master policy/ plan document. Copy provided? ☒ Yes
☐ No

Provided is exhibit *State of Montana Client Contract*, a plan document maintained by the State of Montana.

- b. The summary plan description/ policy certificate(s) applicable to the audit period for each plan. Copy provided? ☒ Yes
☐ No

Provided is exhibit *State of Montana SPD*, a plan document maintained by the State of Montana.

- c. Copies of any memos or letters authorizing plan exceptions ☐ Yes

and/or changes to benefits. Copy provided?

☐ No

Requested copies are provided in the Zip file labeled *Plan Exceptions and Benefit Changes*.

- d. Amendments that affected claim payments during the audit period. Copy provided?**

☐ Yes

☒ No

13. System Software:

- a. What software is used for your claim administration system:**

Delta Dental uses the MetaVance claims processing system.

- b. What is the name of the Software Vendor:**

The MetaVance claims processing system was developed by Hewlett Packard.

- c. How long have you been using this software and claim system?**

The system was first deployed in 2007.

- d. What software is used within your claims system to detect “unbundling” of services:**

Delta Dental’s claims system automatically identifies unbundled claims procedures. We use a comprehensive business intelligence software application from IBM that supports detection and investigation of claims that contain possible fraud by dentists. Through its sophisticated data visualization techniques, the Fraud and Management Abuse System is able to identify dentists who, when compared to peer group norms, are most likely engaging in questionable activities. This system will help not only to enhance Delta Dental’s fraud detection activities, but will also provide important information for practice intervention efforts directed at individual dentists. This proactive approach to data analysis helps Delta Dental manage utilization within its network of dentists, protecting its clients from potential abuse.

e. How long have you been using this “unbundling” software?

Our MetaVance claims processing system has code audit program which bundles/unbundles procedure codes and has been in production since 2007.

14. Business Continuity Plan:

Briefly explain what systems are in place for protecting data in case of a disaster or other business interruption. Also, describe frequency of system back-ups, and type of storage facility used to house back-up data.

We maintain a comprehensive enterprise wide Business Continuity and Disaster Recovery program that is designed to ensure the continuation of all vital corporate and business functions in the event of a disaster. Recovery of the infrastructure that comprises our Data Processing Systems is programmed to recover applications based on their priority to our customers. Customer-facing systems such as telephony, web and email are recovered in as little as 12 hours, our core claims processing system is recovered in 24 hours and peripheral work and reporting systems are recovered within 72 hours such that all critical systems are recovered within 72 hours of a disaster being declared. This program is fully documented and tested at least annually.

Delta Dental performs system-wide back-up of all files every evening. Back-up data is stored off-site and are retrievable within 24 hours, if needed. Delta Dental’s integrated systems route claims processing and customer service inquiries to other locations during any prolonged downtime or disaster.

15 Dedicated Staffing

- a. Is there a staff of people in your company dedicated to providing account services, claim or customer service to this client? X Yes
___ No
- b. If Yes to a. above, please list staff by name and give titles, brief description of responsibility to client, years of experience in the ___Yes

position they are in, years of service in dedicated capacity to this client. ☐ Yes ☐ No

Jim Dole, Account Executive

Jim Dole who has 18 years of employee benefit and group insurance experience, joined Delta Dental in May 2006 as a sales account executive. Mr. Dole coordinates and oversees all internal processes affecting alliance partners, clients, brokers, and prospects, and serves as a strategic advisor for these relationships.

Brittany Chandler, Account Manager

Brittany Chandler began her career with Delta Dental in February 2011. As account manager and the primary point of contact for clients, Ms. Chandler's duties and responsibilities include managing all aspects of account services, open enrollments and benefit fairs, implementing new business and overseeing contract/SPD delivery and renewals.

16. Off-Site Claim Administration

- a. Was the claim processing function outsourced to any subcontractor for this client during the period to be audited? ☐ Yes ☒ No
- b. If "Yes", please explain:

17. Off-Site Member/ Provider Services

- a. Were either the member or provider services functions outsourced to any subcontractor for this client during the period to be audited? ☐ Yes ☒ No
- b. If "Yes", please explain:

Part B: ADMINISTRATOR'S CLAIM FUND ACCOUNT

18. Use of Checking Account:

- a. Are claim checks issued on a checking account of the administrator or the client? ☒ Administrator ☐ Client
- b. If claim checks are issued on the administrator's checking accounts, is this checking account used for other employer or groups' claim checks? All commercial business claims. ☒ Yes ☐ No
- c. If No, is this checking account used for other plans, e.g. dental, ☐ Yes

vision, etc.?

☐ No

- d. Is this checking account used for any purpose other than for claim checks? ☐ Yes
☒ No

e. If Yes, please explain:

- f. Are commissions, fees, or any other expenses paid from this account? ☐ Yes
☒ No

19. Reconciliation of Claim Checking Account:

- a. Who performs reconciliation of claim checking account? ☒ Administrator
☐ Client

20. Refunds And Returned Checks:

- a. How are refunds and returned checks credited back to the client's claim fund?

If an overpayment occurs, we recover the money from the receiver of funds. If an overpayment is made to a participating dentist, we recover the overpayment directly by withholding from future checks. If the recipient was an enrollee, the patient record is flagged so that any incoming claims apply the duplicate payment amount before the balance is paid. If Delta Dental is responsible for an overpayment and funds are irretrievable, we will credit the client's account at our own expense for the amount of the overpayment.

21. Stale Checks:

a. How are stale checks credited back to the client's claim fund?

Delta Dental's Accounting department tracks all unclaimed benefits payments as part of its ongoing reconciliation of our finances. Checks are stale after 365 days from issue date. Escheatment procedures and timeframes vary for each state. In general, our Accounting department keeps an aged list of unclaimed proceeds and reports them based on each state's individual requirements. Delta Dental does not keep funds from unclaimed payments. Clients are credited with voids, stop pays and aged checks.

22. Large Check Approval:

- a. Do claim checks over a pre-determined level require an additional review and approval before issuance?** ☐ Yes
☒ No

*Claims processors are not limited to a specific dollar amount. Claims involving procedures with higher dollar amounts tend to require professional review and approval by our dental consultants, as do extensive or complicated procedures.

- b. If Yes, please describe what review is required and at what check amount?**
- | | |
|----|--------------|
| \$ | Reviewed by: |
| \$ | Reviewed by |
| \$ | Reviewed by |

- c. Describe, or provide a copy of the checklist of items that the above approval is required to entail, e.g. Does the approver review the claim to ensure claimant eligibility, no other insurance, no subrogation potential, proper referral under the plan, other.**

Claims processors follow established referral guidelines and can approve treatment based upon protocols established by Delta Dental. The guidelines, which vary by procedure, complexity and frequency, are built into the claims processing system. When a claim triggers any system edit or procedural flag, it is forwarded to our Audit department or in-house dental consultants for review.

Claims for dental services are directed to our professional claim review area when the services require interpretation by a licensed dentist, when treatment is reviewed for clinical appropriateness and when the treatment patterns of selected providers are reviewed in conjunction with our provider network oversight activities. The following types of claims would be referred to a consulting dentist:

- All procedures that require professional judgment for adjudication
- Miscellaneous procedures; procedures that are not otherwise adequately described by an existing CDT code
- Claims submitted by dentists on review for exceptional utilization

- d. Do claim checks over a pre-determined level require more than one signature? Yes
 X No
- e. If Yes, please describe what review is required and \$
at what check amount?
- f. What is the policy for approval of large checks over a certain level or for a second signature if the person with that authority is not in the office when the signature is required?

Not applicable. Dental claims are reviewed and adjudicated online by authorized processors and consultants. Signatures are not required.

All system accesses require a user-ID, strong password. Access is granted based on the role and business requirements specified in the workforce member's job description.

23. Security:

What type of security does claim system have relating to:

a. Secured log-on passwords and system authorizations?

All systems require a user-ID, strong password. Access is granted based on the role and business requirements specified by the staff's job description. The user-ID defines the functionality available to the user. Users are also required monthly to change their password. Delta Dental maintains a Security Policy that all employees must follow. No ability to mimic a user login exists. Details are Delta Dental confidential.

b. Authorized check signature?

Not applicable. Dental claims are reviewed and adjudicated online by authorized processors and consultants. Signatures are not required.

All system accesses require a user-ID, strong password. Access is granted based on the role and business requirements specified in the workforce member's job description.

c. Separate duties and limit of access to eligibility maintenance, provider maintenance, claim adjudication?

All systems require a user-ID, strong password. Access is granted based on the role and business requirements specified by the staff's job description. The user-ID defines the functionality available to the user.

d. Authorizations to override system edits and limitations?

Delta Dental's dental consultants are the only processors who may override usual and customary fee determinations. The system records all actions taken on a claim, whether they are system automated or applied by a claims processor. Manual intervention is only necessary for those claims flagged for additional review. The consultant can give approval for the claim to go forward for payment or denial. Our Internal Audit department performs regular reviews of claims processed using override codes.

24. Check Processing:

- a. Are claim payments to providers batched (multiple patient accounts paid on one check to the provider on a designated time schedule)? X Yes
___ No

- b. If Yes, what is the schedule for releasing batch payments?

Claims payments are batched for weekly payment.

- c. Is assignment of benefits honored for payment of claims from non-Network or non-participating providers? X Yes
___ No

The member must sign (or have a signature on file) requesting payment be issued to a non-Delta Dental dentist otherwise the member is reimbursed directly. Delta Dental dentists are paid directly.

- d. If No, what controls are in place to validate the authenticity of a claim that is resulting in a check being issued to an employee?

25. Direct Pay (COBRA & Retirees) Premium Accounting:

- a. Are premiums for COBRA & Retirees collected by the administrator or by the client? ___ Administrator
X Client

Part C: ADMINISTRATOR'S CLAIM ADJUDICATION AND ELIGIBILITY MAINTENANCE PROCEDURES

26. Claim Administration Workflow:

- a. Please provide a general workflow that a typical claim submitted for payment under this client's plan would follow from date the claim is sent (include location claims are sent to) to date the Explanation of Benefits is sent to the member. Include locations and departments that the claim process routes through and how the claim is tracked during the workflow process.

Claims are received by mail or electronically.

Mailed Claims

Mailed claims are mailed to Delta Dental Insurance Company's Alpharetta, Georgia processing facility. The mailing address is:

Delta Dental
P.O. Box 1809
Alpharetta, GA 30023-1809

Upon receipt, claims and associated documentation are scanned into the processing system. These claim images become a permanent, retrievable record in the patient's folder once entered into the system. Original claim documentation is kept in paper form for three weeks after receipt.

Scanned claims are optically read in the Formworks data capture system. Claims that cannot be optically read are entered from the claim image. Our claims processing environment is paperless.

Once claims are optically read, and/or key verified and validated, they are uploaded to the host claim system. Those claims that pass all internal checks will auto-adjudicate without further human intervention. Approximately 88% of incoming documents are automatically adjudicated. Those that do not automatically adjudicate are routed through the MACESS work management system to a claims examiner based on the type of data or information required to adjudicate the claim. If a procedure has to be routed to one of the staff dental consultants, the system will detect which procedures require this level of review and route the claim automatically. Once the appropriate level of review has been completed, the claim is adjudicated.

Claims payments are batched for weekly payment. Checks and/or statements are issued to the dentist and enrollees.

Electronic Claims

Our system receives standard format 837 HIPAA-compliant transactions from the

clearinghouse every night. Our host system has checks and balances built in at the field level and will reject any claim that is transmitted without a required field.

Our system will then check the incoming data against our internal databases to confirm patient's eligibility for services, dentist's status and fees, group benefits and frequency limitations for procedures. If any of the data does not match, the claim may require further review.

Claim payments and statements are issued weekly from our Rancho Cordova location.

See exhibit *Claims Workflow*.

27. Eligibility Changes:

- a. **Who is responsible for making updates to the list of eligible employees and dependents in your claims payment system?**

Eligibility file is received electronically from the State on a bi-weekly basis,

- b. **What medium is used to transfer eligibility changes and new additions from the employer to you?**

☒ Electronic ☐ Paper forms

- c. **How frequently does your system get updated with eligibility changes, additions, and terminations?**

Eligibility updates are received from the State on a bi-weekly basis (on Wednesdays.)

28. Investigating Dependent Eligibility:

- a. **Provide a copy of your administrative procedures for verifying the continued eligibility for dependents over the plan's limiting age (i.e. handicapped dependents) Copy provided?** ☐ Yes ☒ No

The State is responsible for providing Delta Dental with accurate dependent eligibility status.

- b. **Provide a copy of your procedures for recognizing and** ☐ Yes

investigating dependents that may not be eligible for coverage (i.e. grandchildren). Copy provided?

X No

The State is responsible for providing Delta Dental with accurate dependent eligibility status.

29. Hours Bank:

a. **Is there an “hours bank” or other continued eligibility system for participants who are not working?** Yes
X No

b. **If yes, how does it work?**

Not applicable

30. Other Insurance Coverage Investigation:

a. **Provide a copy of your administrative procedures for the initial and continued verification of the existence of other group insurance that may be primary over the plans being audited for dependents. Copy provided?** Yes
X No

b. **If not provided, please select one of the options below that most precisely describes your corporate policy:**

 Investigative letters sent by the claims administrator to the employee no less than once per 12 month period, or upon receipt of a dependent claim.

 No investigative letters sent, claims administrator uses information regarding other primary insurance from the provider via the claim submission, from the employee by phone, or from the employer.

X **Other – please describe:**

Coordination of Benefits (COB) validation is done on a claim-by-claim basis. COB information received is processed manually by a Claims team member based on the information provided with the claim. If a member calls into the Customer Service department with outside coverage information, the Contact Center will initiate a service form to have the additional coverage information applied.

Documentation can be viewed during the on-site audit.

c. **How does your system define and calculate COB savings?** X Yes

Delta Dental's COB Savings report provides the total dollar amount paid by Delta Dental and the total savings (in dollars and as a percentage) due to COB. The report also lists Delta Dental's obligation before COB is applied and the actual dollar amount paid by Delta Dental once COB is applied to dual coverage claims.

- d. **Provide a copy of a report showing the COB Savings for this client for the past 24 months based on the above definition? Copy provided?** ☐ No

Provided as exhibit *State of Montana COB Savings Report*. State of Montana has been a client effective January 1, 2013. Provided report is based on the most recent 12-month period (January – December 2013).

31. Usual, Reasonable and Customary Pricing:

- | | |
|--|---|
| <p>a. What is the source of your Usual, Reasonable and Customary Database? (e.g. Ingenix, ADP, Proprietary)</p> <p>b. What is the date of your most recent update?</p> | <p>Proprietary database of all dentists' fees submitted and published industry data.</p> <p>All fees are reviewed at least annually and may be adjusted based on results of extensive analysis of many factors including: network size, overall discount and competitive market demands. Dates vary by geographic region.</p> |
|--|---|

c. At what percentile is UCR set?

<u> 60th </u>	<u> 80th </u>	<u> 90th </u>	Other <u>Our standard percentile varies by state. The variance ranges between the 50th and 90th percentile. Percentiles are set to reflect allowances that are sensitive to local standards of the professional community and competitive factors.</u>
-----------------	-----------------	-----------------	--

32 Data Codes:

What coding schemes do you use for the following data elements:

a. **Provider Identification Number**

 X Tax ID

Other Dentist license number, NPI

(1) Do you use a suffix on the provider ID?

 Yes

 X No

(2) If yes, describe:

b. **Employee Identification:**

 Social Security Number

Other X

c. **Dependent Identification:**

 Social Security Number

Other X

d. **Procedure Codes:**

 CPT

 HCPCS

Other CDT

e. **Diagnosis Codes:**

 ICD-9

Other N/A

(1) How many diagnosis codes are recorded for each claim line?

N/A

33. Claim Adjustments:

a. How do adjustments to correct claim payments appear in the claim system?

Claims status codes will change to Status YJ (from Y). Adjustment service lines will be seen in a sequence where the first processing of the service line will be seen on the system as it was paid initially. Above that service line, an exact copy of the service line will appear that functionally reverses the initial processing. Dollar amounts on that line are expressed as negative values. The next line will show the new adjusted processing of the service line.

d. For manually submitted paper claims, how do you validate the authenticity of the claim?

Delta Dental's claim system has numerous edits and flag indicators to detect erroneous data. Claims processors intervene manually when a claim is suspended for the following reasons:

- Invalid procedure codes
- Dates of service outside the contract period
- Dentist's license number not on file
- An employee with dual coverage
- Alternative treatment possibility
- Missing eligibility history
- A claim that is over one year old

Our claims system has additional edits and flag indicators to assist in detecting fraud in its earliest stages. Claim data is summarized to identify potential anomalies in dental practice patterns. Specific detection procedures include:

- Performing history cross-checks on all flagged items to determine any services that fall outside the scope of the client's contract.
- Analyzing utilization reports to compare dentists to their peers and identify potentially abusive dental practice patterns.
- Monitoring contracted fees automatically through the claims processing system, protecting the enrollee from balance billing.

36. Overpayment Recovery:

- a. Do you have a minimum dollar amount of overpayment under which you will not pursue overpayment recovery? (i.e. if you identify an overpayment of less than \$25 you will not take action to recover that overpayment.) ___ Yes
 X No
- b. If Yes, what is the minimum dollar amount? \$ N/A

37. Participating Provider Networks and Global Contracts:

- a. What are the name(s) of any Global Contracts that provide additional discounts or savings to this plan:**

Delta Dental networks are *Delta Dental PPOSM* and *Delta Dental Premier[®]*.

- b. What are the name(s) and geographical territories covered by the provider networks used by these plans:**

Unique to Delta Dental, our PPO network of 207,000 dentist locations nationwide is supported by our Premier network that provides additional access and contracted fees to enrollees who visit a non-PPO dentist but remain within the Delta Dental Premier network (292,000 participating dentist locations, representing 80% of dentists nationwide.) Our PPO plans still allow for freedom of choice so enrollees can choose to visit a non-contracted dentist and still receive benefits on an out-of-network basis.

- c. Will the original contracts with participating providers be made available to CTI's auditors while they are on-site for the field audit?** X Yes
___ No

Upon receipt of a provider list from the State and/or CTI's auditors, Delta Dental can provide copies of original contracts without provider fee data to be viewed on-site.

- d. What % of the claims come from participating providers and global contracts?** 97.2%*

*45.7% are PPO contracts and 51.5% are Premier. Note there is overlap between our PPO and Premier dentists. Approximately 68% of Delta Dental PPO dentists are also Delta Dental Premier dentists.

- e. Provide available reports showing participating provider savings, percent of claims dollars discounted in-network, percent (frequency) of claims discounted by in-network providers for the audit period. Reports provided?** X Yes
___ No

See exhibit *State of Montana Cost Savings Report*. Provided report is based on the most recent 12-month period (January – December 2013).

38. Subrogation:

- a. Which of the following best describes your policy for pursuing details regarding a claim that has the potential for subrogation or right of recovery?

- ☐ Pend the claim and seek accident details and/ or a signed subrogation agreement with payment only after receipt of both items.
- ☐ Pay the claim and subsequently follow up on accident details and/ or a signed subrogation agreement.
- ☒ Other, please explain:

Delta Dental does not actively subrogate dental claims.

- b. Explain how the client is informed of any recoveries experienced by subrogating claims. Reports? Frequency of Reports?

Not applicable

- c. Do you outsource subrogation recovery?

☐ Yes

☒ No

Not applicable

- d. If the subrogation function is NOT outsourced, do you have a dedicated Subrogation Unit or personnel to investigate and follow up on subrogatable claims?

☐ Yes

☒ No

Not applicable

- e. If Yes, what is the name and address of the outsource firm?

Not applicable

- f. If you outsource subrogation recovery activity provide a copy of

☐ Yes

your internal policies and procedures for referring cases to the outsource firm and for follow-up on recovery status. Copy provided?

X No

Not applicable

- g. Provide your or your vendor's activity report showing all open and closed subrogation cases during the audit period. If the case was closed indicate the amount and date of recovery received. Copy provided?**

 Yes

X No

Not applicable

- h. Is there a minimum dollar amount under which you will not pursue subrogation recovery? (i.e. if the claim payment is less than \$500 you will not pursue subrogation.)**

 Yes

X No

Not applicable

- i. If Yes, what is the minimum dollar amount?**

\$N/A

Not applicable

- j. Do subrogation recoveries result in claim adjustments in your claim system?**

 Yes

X No

Not applicable

- k. If Yes, is there an adjustment code in your system that allows you to track all claim adjustments made as a result of subrogation recoveries?**

 Yes

X No

Not applicable

39. Work Related Claims:

- a. **Explain your procedures for identifying, investigating, and processing claims that may be related to a Work Related illness/injury.**

If dental treatment is the result of a work-related illness or injury, the treating dentist is required to provide the date of the illness/injury, description and any amount paid.

- b. **Are claims paid prior to investigating for potential work related causes?** ☐ Yes
☒ No

Not applicable

- c. **Is there a minimum claim payment amount that must be issued before an investigation would be initiated?** ☐ Yes
☒ No

Not applicable

- d. **If Yes, what is the amount?** \$ N/A

40. Lifetime Maximum Accumulations

Items 40a – 40f are not applicable to this dental plan.

- a. If there is a Lifetime Maximum on health plan benefits under this plan, does it include prescription drug claim payments as well as all health plan benefits? ☐ Yes
☐ No
☐ NA (no Lft. Max.)
- b. Describe your process and system support for accumulating the Lifetime Maximum on health plan benefits:
- c. Since your company has been administering this plan has any individual exceeded the Lifetime Maximum on benefits? ☐ Yes
☐ No
- d. If Yes, please provide a list of the individuals who have exceeded the Lifetime Maximum of this plan since you have been the administrator. List provided? ☐ Yes
☐ No
☐ NA (no-one exceeded)
- e. If you became the administrator of this plan's dental claims within the past 5 years, did you receive and accumulate claims paid by the prior ☐ Yes
☐ No

administrator to the Lifetime Maximum Accumulations of this plan?

☐ NA
(TPA for >
5 years)

- f. If you administer more than one health plan for this employer and an employee transfers from one plan to another, do you “roll” their Lifetime Maximum Accumulations to the new plan?

☐ Yes

☐ No

☐ NA
(only one
plan)

41. Hospital Precertification:

- a. If pre-certification of hospital admissions and/or surgery is required, who performs these functions?
- b. How does your system record that pre-certification was performed and the final determination?

42. Case Management:

- a. Who performs large claim case management?
- b. How are claims identified for large claim case management?
- c. How are savings obtained through case management reported to the client?

43. Disease Management:

- a. Who performs the disease management of chronic illness?
- b. How are claims identified for disease management?
- c. How are disease management results reported to the client?

44. Out-of Network Negotiated Claims:

Explain or provide a copy of your internal administrative policies for discount negotiation on out-of-network claims.

45. Pre-Existing Conditions:

- a. Describe your procedure for investigating for pre-existing conditions.
- b. Describe your procedure for verifying Creditable Coverage Forms.

46. Telephone Inquiries:

- a. **Explain how telephone inquiry response time and abandonment rate is monitored.**

Symposium reports capture call accounting information (e.g., average delay, service level and abandonment rate). All phone calls are tracked in the MACCESS workflow-tracking system using service forms.

- b. **Provide a copy of the report that was used to monitor telephone** ☒ Yes

inquiry response time and abandoned calls for the audit period. No

Copy provided?

See exhibit 2013 Contact Center Performance Report.

47. Claim Appeals:

a. Explain how the response time on claim appeals is monitored?

All incoming correspondence (e.g., verbal, written or electronic) is logged within our MACCESS tracking system. Any enrollee complaint received concerning a dentist or Delta Dental is routed to the Grievance and Appeals unit for resolution. Tracking guidelines were developed to meet regulatory standards. Findings and decisions regarding the complaint are sent to the enrollee within 30 days of receiving the complaint. Second level appeals are handled through the State of Montana.

b. Provide a copy of the report for the most recent 12 months that is used to monitor claims appeals response time. Copy provided? X Yes
No

Provided as exhibit *State of Montana Member Complaints Report*.

48. Claim Turnaround Time:

a. Explain how claim turnaround time is calculated?

Delta Dental calculates turnaround time by counting all calendar days (including weekends and holidays) from the initial receipt of a claim until claim adjudication is complete. Receipt date is the date the claim is received by Delta Dental. Processed date is the date a claim is adjudicated online.

b. Is it calculated the same way for the original claim as it is for an adjustment to the original claim? X Yes
No

c. If No, please explain how claim turnaround is tracked for an adjustment to an original claim?

Not applicable

49. Reinsurance:

- a. Does this Client have a reinsurance contract? ☐ Yes
☐ No
- b. If Yes, please provide a copy of the reinsurance contract(s) in force during the audit period. Copy provided? ☐ Yes
☐ No
- c. If Yes, does your firm file for reinsurance reimbursements with the reinsurance carrier on behalf of the Client? ☐ Yes
☐ No
- d. If Yes to c., please provide a copy of the reinsurance filing reports for any contract year that ended during the audit period and the end of the most recent month of the audit period showing reinsurance reimbursements filed for and received. Copy provided? ☐ Yes
☐ No
- e. Please explain how and by who in your company reinsurance reimbursements are credited to the Client?

50. Provider Fraud and Abuse:

- a. Does your company have a dedicated staff for monitoring provider fraud and abuse? ☒ Yes
☐ No
- b. If Yes to a., please describe the staff's make-up, expertise and functions specifically with regard to the challenge of identifying and pursuing fraud and abuse on behalf of your health care clients.

Our Network Oversight and Compliance staff is comprised of compliance analysts who are responsible for auditing the financial and dental records a dentist keeps on patients. All current analysts possess either a bachelor's degree in criminal justice or a related field and several years of dental claims auditing experience or over 10 years of dental claims/office experience

- c. What efforts does your company take to take legal action against providers who have shown indication of committing fraud or abusing one of your client's plan of benefits?

Suspected insurance fraud cases are referred to law enforcement officials. Network Oversight and Compliance then assists law enforcement in any capacity requested to assist in the prosecution of these cases.

- d. Does your company utilize links to external reports of providers who have been indicted or sanctioned for having committed fraud (such as Medicare's database of indicted providers)? ☒ Yes
☐ No

- e. If Yes to d., please list the links and resources that your company utilizes.**

<https://www.npdb-hipdb.hrsa.gov/>

Along with using the National Practitioners Database, Delta Dental also uses software that scours the web for articles regarding dentists who have had negative press related to various matters including criminal issues.

- f. Does your company utilize software designed to identify potential provider fraud?** ☒ Yes
☐ No

- g. If Yes to f., please list the software name and versions.**

Delta Dental uses a comprehensive business intelligence software application from IBM that supports detection and investigation of claims that contain possible fraud by dentists. Through its sophisticated data visualization techniques, the Fraud and Management Abuse System is able to identify dentists who, when compared to peer group norms, are most likely engaging in questionable activities. This system helps not only to enhance Delta Dental's fraud detection activities, but also provides important information for practice intervention efforts directed at individual dentists. This proactive approach to data analysis helps Delta Dental manage utilization within its network of dentists, protecting its clients from potential abuse.

Part D: HIPAA COMPLIANCE

51. Privacy Compliance:

- a. Has your organization signed a Business Associate agreement with this employer?** ☒ Yes
☐ No
- b. Have all employees with access to Personal Health Information (PHI and ePHI) been made aware of the security and confidentiality rules under HIPAA?** ☒ Yes
☐ No
- c. Have you taken all appropriate measures to safeguard protected health information (PHI) within your organization?** ☒ Yes
☐ No
- d. Have you established a procedure to report complaints of violations of HIPAA to this employer?** ☒ Yes
☐ No

52. Electronic Data Interchange (EDI) Compliance:

- a. Please explain how providers are currently able to send claims and inquiries to you in a HIPAA compliant EDI format?**

Delta Dental supports standard EDI transactions sets. Covered HIPAA transactions include:

- 270/271 – Eligibility Benefit Inquiry and Response
- 276/277 – Health Care Claim Status Inquiry and Response
- 834 – Enrollment and Maintenance in a Health Plan
- 837D – Health Care Claims or Equivalent Encounter Information for Dental

In addition, Delta Dental currently utilizes health care clearinghouses as intermediaries for the inquiry and claim transactions listed above.

53. Compliance With Standards For Data Security Protections:

- a. Have you performed and documented a risk analysis to assess potential risks associated with your organizations receipt or transmission of electronic personal health information (ePHI) at this time?** ☒ Yes ☐ No
- b. Have you conducted a security audit within the past 6 months to compare your organizations current practices and technology to the HIPAA security requirements to identify gaps that must be closed?** ☒ Yes ☐ No
- c. Has your organization documented its rationales in instances where it has taken advantage of the flexibility in HIPAA's security requirements for meeting security specifications?** ☒ Yes ☐ No
- d. Please provide an overview of your organization's policies and procedures for the security of members' protected health information.** ☐ Yes

Copy provided?

X No

Delta Dental has designated compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including recent regulatory changes, as one of its top corporate priorities. Our compliance efforts include, but are not limited to, the following measures which are designed to ensure current and future compliance with HIPAA:

- Implementation of comprehensive HIPAA policies and procedures that address:
 - Protection of PHI through all work processes
 - Administrative, technical, and physical safeguards
 - Requests for PHI by various individuals or agencies – procedures for authentication, verification, authorization, access, amendment, restrictions, and accounting of disclosure of PHI
 - Use of PHI by business associates
 - Training
- Maintaining security measures that include controlled building access, computer passwords, and signed confidentiality statements by employees upon hire
- Thorough training of new employees and on-going refresher training of all employees
- Internal contacts and legal department reviews of new laws and regulations to ensure all procedures and documents are in compliance
- Distribution of Business Associate agreements to all of our business partners (signed agreements are tracked through our internally developed compliance database)
- Notice of Privacy Practices for enrollees
- Secure servers, website and telephone security prompts; entity authentication capabilities; and, data encryption technology
- Standardized transactions and code sets
- Tracking of non-routine uses of PHI through our HIPAA database

Delta Dental mandates HIPAA compliance as one of its top corporate priorities. We consider our privacy and security policies confidential and proprietary. Key milestones and a copy of our latest Notice of Privacy Practice are available on our website at: deltadentalins.com/about/privacy/hipaa-privacy.html.

-
- e. Please identify any security breaches that have been recorded and reported that affect our mutual client and covered members.

Report provided?

☐ Yes
☒ No

There have not been any breaches involving this client.

ELECTRONIC SCREENING REPORT

State of Montana Health Care Plan

**Administered by:
Delta Dental**

Audit Period: January 1, 2013 to December 31, 2013

Prepared: April 16, 2014

ELECTRONIC SCREENING REPORT

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Overview

Electronic Screening Objective

The objective of our electronic screening is to identify and quantify claim administration system problems that appear to be causing payment errors.

Electronic Screening Scope

CTI performed electronic screening of 100 percent of each of the dental service lines that comprise a dental claim processed by Delta Dental during the 12 month period of January 1, 2013 to December 31, 2013. Delta Dental processed 56,257 claims (including adjustments) for 21,999 claimants representing 139,618 separate dental service line items and resulting in \$7,422,412 in payment by the plan.

A complete list of the ESAS® Screening Categories and Subcategories is shown in Figure 1. below.

Figure 1.

Category	ESAS® Dental Plan Control Risk Categories	Evaluate for Process Improvement	Quantify Errors
1. Duplicate Payments to Providers and/or Employees			
		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Plan Limitations			
	2.1 Specific to Plan Provisions; <ul style="list-style-type: none"> Dollar Limitations, Number of Visit Limitations 	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
	2.2 Payments for Claims Filed After Timely Filing Limit	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Plan Exclusions			
	3.1 Specific to Plan Provisions such as: <ul style="list-style-type: none"> Prosthetic Appliances Dental Implants Cosmetic Procedures Orthodontia 	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. Fraud, Waste and Abuse			
	4.1 Large Payments Made Direct to Employees	<input checked="" type="checkbox"/>	
	4.2 Invalid or Unlisted Procedure Codes	<input checked="" type="checkbox"/>	
5. Coordination of Benefits			
	5.1 Paid Primary; Should be Secondary to Other Group Insurance	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Electronic Screening Methodology

CTI used its proprietary software, ESAS®, to screen each dental service line processed. ESAS® applies several hundred screening parameters to each line to identify claims that may be paid in error. Any service line edited by ESAS® is considered “red-flagged,” meaning it has the potential for having been over- or under- paid based on the screening parameters set into ESAS® and the claim data provided by the claim administrator. To validate ESAS® screening findings, CTI selects a targeted sampling from the “red-flagged” service lines to test. This is the targeted sampling component of our electronic screening process. Our experience has shown that this type of sampling is necessary in order to validate that the claim data and the eligibility data provided was adequate to produce reliable screening results. CTI’s auditors also followed up on screening results while they were on-site. While CTI is confident in the accuracy of our electronic screening results, it is important to note that the dollar amounts associated with the electronic screening results shown below represent potential, not actual, overpayments and process improvement opportunities. Additional testing of these claims by Delta Dental and State of Montana would be required to substantiate the findings and to provide the basis for remedial action planning.

CTI is not authorized to tell the Claim Administrator to recover overpaid amounts. The process and impact of recovering overpayments should be discussed by the Plan Sponsor and the Claim Administrator. If recovery is not pursued, these findings still represent the opportunity for future savings if systems and procedures can be improved to eliminate future similar payment errors.

Procedures Followed

The specific procedures that were followed to complete this electronic screening and analysis of claims data for State of Montana are as follows:

- **Document Review**

We conducted an in-depth review of State of Montana administrative services agreement and plan documents. These documents provided the specifications we used in setting the parameters in ESAS® and analyzing the electronically screened results.

- **Data Conversion**

We converted claims data provided by Delta Dental into ESAS® database formats. The converted data was reconciled against control totals and checked for reasonableness before proceeding with electronic screening.

- **Electronic Screening**

To the extent the claim data provided to us by Delta Dental supported the ESAS® algorithms, we utilized ESAS® to screen State of Montana Plan claims data.

- **Auditor Analysis**

If the category represented Potential Amounts at Risk and the amount “red flagged” within that category was material, our auditors reviewed the category findings to confirm that the electronically screened potential errors appeared valid and to select the best examples of potential overpayments to conduct further substantive testing.

- **Substantive Testing and Additional Analysis**

For this State of Montana audit a total of 10 red flagged cases were selected and Substantive Testing Questionnaires were prepared for each and sent to Delta Dental for completion. A CTI auditor reviewed Delta Dental’s questionnaire responses and supporting documentation. Copies of Delta Dental’s responses to the questionnaires are provided in Exhibit A. (Questionnaire responses presented in Exhibit A. have been redacted to eliminate personal health information.)

Based on the responses from Delta Dental and further analysis of the ESAS® findings in light of those responses, CTI removed any false positives that could be systematically identified from the Potential Amounts at Risk. False positives typically occur because certain claim data was misleading or inadequate.

- **Review of Preliminary ESAS® Findings and Reporting**

We reviewed the preliminary findings from the electronic screening and analysis process with the Claim Administrator to ensure that we had complete understanding and agreement (where possible) on the reported results before preparing this report section and the Executive Summary.

Findings by Screening Category

This section of the report includes the ESAS® Summary report showing by category the number of line items or claims and the total potential amount at risk that remain now at the conclusion of our analysis and substantive testing protocols.

Following the ESAS® Summary report is a detailed explanation of our Substantive Testing results, findings and recommendations if it is our opinion that process improvement or recovery/savings opportunities exist.

Note: If CTI is making an improvement recommendation, it will be denoted by a “Yes” in the final column of the ESAS® Summary reports.

ESAS - Summary (as of 03/21/2014)

Categories for Potential Amount At Risk

Client: Montana State - Delta Dental

Screening Period: 01/01/2013 - 12/31/2013

Analysis Final Results

Claims Red Flagged	1,686
Claimants Red Flagged	1,395
Paid Amount Red Flagged	\$246,592
Potential Amount at Risk:	\$300,333

Category	Lines	Cmnts	Description	Charge Amount	Paid Amount	Potential Amount At Risk	Improvement Recommended
Duplicate Payments to Providers and/or Employees							
DP2B	40	12	Duplicate Payments to Providers and/or Employees	\$8,686	\$15,213 *	\$6,527	
DP2C	798	243	Duplicate Payments to Providers and/or Employees	\$45,484	\$90,733 *	\$45,248	
DP3C	205	42	Duplicate Payments to Providers and/or Employees	\$3,798	\$12,264 *	\$8,466	
Plan Limitations							
PL03	25	24	Full Mouth X-rays	\$2,479	\$1,868	\$1,868	Yes
PL04	102	90	Cleanings	\$7,854	\$5,530	\$5,530	Yes
Plan Exclusions							
DX04	256	204	Dental, Other X-Rays/films	\$23,611	\$0	\$0	
DX17	612	229	Dental, Extractions Bony Impactions	\$218,882	\$129,873	\$129,873	
DX22	1677	891	Dental, Other Anesthesia	\$256,844	\$102,821	\$102,821	

* The amount detailed is based on Benefit Total, which equals
Coinsurance + Copayment + Deductible + Paid

Duplicate Payments

OBJECTIVES: To identify provider services paid more than once. Further, to identify procedural deficiencies of the administrative process and to quantify conservatively the additional cost to a plan caused by duplicate payments.

Initial Screening and Analysis

Electronic screening of all service lines processed revealed certain service lines to have potentially been paid more than once, resulting in a benefit total (the accumulation of payment, deductible and coinsurance applied to the out of pocket accumulation) greater than the charged amount for that service.

Substantive Testing

Substantive Testing Questionnaire (QID) numbers 1-2 were sent to Delta Dental which responded to all questionnaires submitted. Copies of the responses are provided in Exhibit A.

Substantive Testing results are shown in the following report entitled: “Substantive Testing Detail Report – Duplicate Payments.”

Although the claims tested were not duplicates, CTI is unable to validate that the remaining claims have been processed correctly without further testing.

Recommendation(s)

In the category of Duplicate Payments, after removal of any cases that Delta Dental was able to document as not having been overpaid, CTI has no recommendations at this time

Substantive Testing Detail Report Duplicate Payments

Client: State of Montana Dental

Audit Period January 1, 2013 to December 31, 2013

Questionnaire ID Numbers: 1-2 (See Exhibit A. – Substantive Testing Questionnaire Responses)

QID No:	Flag Type	Flag Description	Overpaid Amt	Delta Response (For full response see questionnaire in Exhibit A)
1	DP2C	Service line paid twice on separate claim numbers	\$0.00*	Disagree, claims were on different dependents.
2	DP2C	Service line paid twice on separate claim numbers	\$0.00*	Disagree, claims were on different dependents..

*Potential overpayments that were tested and determined to not be overpaid have been removed from total potential overpaid, however other cases identified by ESAS® cannot be removed without further investigation.

Plan Limitations

OBJECTIVES: To identify services that have exceeded plan limitations on quantity, frequency or benefit amount. Further, to identify procedural deficiencies in the administrative process and to quantify conservatively the additional cost to a plan caused by payments in excess of the plan limitations.

Initial Screening and Analysis

Electronic screening of all service lines processed revealed certain service lines potentially to have been overpaid as a result of exceeding the plan's limitations for coverage of:

- Full Mouth/Panorex X-rays
- Routine Cleanings

Further analysis of the service lines flagged confirmed the potential for process improvement and overpayment of claims to be sufficiently material to warrant further testing.

Substantive Testing

Substantive Testing Questionnaire (QID) numbers 3-10 were sent to Delta Dental. Delta Dental responded to all questionnaires submitted. Copies of the responses are provided in Exhibit A. The results confirmed the potential for process improvement and overpayment of claims.

Recommendation(s)

In the category of Plan Limitations, after removal of any cases that Delta Dental was able to document as not having been overpaid, the following recommendations are made:

Limitation Subcategory	Potential Recovery Amount	# of Claimants	Recovery/Process Improvement Opportunity
Full Mouth/Panorex X-rays	\$1,868	24	Discussion should be had with Delta Dental regarding focused audit to determine recovery potential on these claims and whether it is the intent of the State of Montana to pay for both a Full Mouth X-rays and a Panorex X-ray.
Routine Cleanings	\$5,530	90	Discussion should be had with Delta Dental regarding focused audit to determine recovery potential on these claims and whether system edits could be refined to allow for better control against claims being paid in excess of the Plan's limits.

Substantive Testing Detail Report Plan Limitations

Client: State of Montana Dental

Audit Period January 1, 2013 to December 31, 2013

Questionnaire ID Numbers: 3 - 10 (See Exhibit A. – Substantive Testing Questionnaire Responses)

QID No:	Flag Type	Flag Description	Overpaid Amt	Delta Response (For full response see questionnaire in Exhibit A)
3	PL01	Oral Examinations	\$0.00*	Disagree. Claim was an adjustment.
4	PL03	Full Mouth X-rays	\$71.00*	Disagree. Delta allows both an Full Mouth and Panorex X-ray.
5	PL03	Full Mouth X-rays are	\$71.00*	Disagree. Delta allows both an Full Mouth and Panorex X-ray.
6	PL03	Full Mouth X-rays	\$80.00*	Disagree. Delta allows both an Full Mouth and Panorex X-ray.
7	PL04	Routine Cleanings	\$71.00*	Agree. Third cleaning paid in error.
8	PL04	Routine Cleanings	\$57.00*	Agree. Third cleaning paid in error.
9	PL04	Routine Cleanings	\$71.00*	Agree. Third cleaning paid in error.
10	TF12	Last service date to process date; 12 mths	\$0.00*	Disagree. Claim was submitted within 12 months. .

*Potential overpayments that were tested and determined to not be overpaid have been removed from total potential overpaid, however other cases identified by ESAS® cannot be removed without further investigation.

Exhibits

A. Substantive Testing Questionnaire Responses and CTI Conclusions

B. Delta Dental Response to Working Draft Report

Exhibit A.

**Substantive Testing Questionnaire Responses
and CTI Conclusions**



Duplicate Payments to Providers and/or Employees
Substantive Testing Questionnaire

Questionnaire ID:	1
Client:	Montana State - Delta Dental
Audit Period:	01/01/2013 - 12/31/2013

The above referenced individual was identified by ESAS® as having potential duplicate claim payments.

The claims listed below appear to be duplicates. For each claim, please provide the following:

1. A copy of your administrative procedures used in identifying and preventing duplicate claim payments.
 2. A copy of each bill.
 3. If the listed claim(s) are duplicates, provide documentation that the overpayment has been refunded and credited to the client's account.
-

Administrator's Response

This is not a duplicate payment; 2 dependents received treatment

Conclusion

No procedural deficiency or overpayment identified. These claims are not duplicates based on the fact that the claims in question involved two different dependents. Any other claim like this one flagged by ESAS can only be considered correct when it has been verified that the claims in question involved different dependents.

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Duplicate Payments to Providers and/or Employees
Substantive Testing Questionnaire

Questionnaire ID:	2
Client:	Montana State - Delta Dental
Audit Period:	01/01/2013 - 12/31/2013

The above referenced individual was identified by ESAS® as having potential duplicate claim payments.

The claims listed below appear to be duplicates. For each claim, please provide the following:

1. A copy of your administrative procedures used in identifying and preventing duplicate claim payments.
 2. A copy of each bill.
 3. If the listed claim(s) are duplicates, provide documentation that the overpayment has been refunded and credited to the client's account.
-

Administrator's Response

This is not a duplicate payment; 2 dependents received treatment

Conclusion

No procedural deficiency or overpayment identified. These claims are not duplicates based on the fact that the claims in question involved two different dependents. Any other claim like this one flagged by ESAS can only be considered correct when it has been verified that the claims in question involved different dependents.

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Plan Limitations

Substantive Testing Questionnaire

Questionnaire ID:	3
Client:	Montana State - Delta Dental
Audit Period:	01/01/2013 - 12/31/2013

The above referenced individual was identified by ESAS® as having incurred claim payment(s) for conditions which are limited under this Plan.

1. The claims relating to charges for the plan limitation in question are listed below. Please provide documentation showing that the benefits for oral examination have not been exceeded based on the plan limitations.

Administrator's Response

Original claim incorrectly processed under the subscriber. Response: Adjustment Claim Number 20133163403669 completed 7/15/2013.

Conclusion

No procedural or payment deficiencies identified. Claim is not a duplicate; claim was adjusted. Any other claim like this one flagged by ESAS can only be considered to be processed correctly if has been verified that the services in question were adjusted

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Plan Limitations

Substantive Testing Questionnaire

Questionnaire ID:	4
Client:	Montana State - Delta Dental
Audit Period:	01/01/2013 - 12/31/2013

The above referenced individual was identified by ESAS® as having incurred claim payment(s) for conditions which are limited under this Plan.

1. The claims relating to charges for the plan limitation in question are listed below. Please provide documentation showing that the benefits for complete (full mouth) x-rays have not been exceeded based on the plan limitations.

Administrator's Response

System Processed per EBD;

Procedure D0210 Benefit is limited to one full mouth series within a 5 year period.

Procedure D0330 Benefit is limited to one panoramic film within a 5 year period.

Conclusion

A procedural error and \$71.00 overpayment have been identified. The exception to the frequency limitation for full mouth series and panorex x-rays for State of Montana claimants that Delta Dental applies when a claimant has both types of x-rays is not supported by the plan provisions in the State of Montana Dental Plan booklet. The State of Montana and Delta Dental should discuss this issue and determine if the State of Montana agrees with this standard operating procedure for the payment of full mouth and panorex x-rays when billed by different providers of service. Any other claim like this one flagged by ESAS can only be considered to be processed correctly if it has been been paid at the direction of the State of Montana.

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Plan Limitations

Substantive Testing Questionnaire

Questionnaire ID:	5
Client:	Montana State - Delta Dental
Audit Period:	01/01/2013 - 12/31/2013

The above referenced individual was identified by ESAS® as having incurred claim payment(s) for conditions which are limited under this Plan.

1. The claims relating to charges for the plan limitation in question are listed below. Please provide documentation showing that the benefits for complete (full mouth) x-rays have not been exceeded based on the plan limitations.

Administrator's Response

System Processed per EBD;

Procedure D0210 Benefit is limited to one full mouth series within a 5 year period.

Procedure D0330 Benefit is limited to one panoramic film within a 5 year period.

Conclusion

A procedural error and \$71.00 overpayment have been identified. The exception to the frequency limitation for full mouth series and panorex x-rays for State of Montana claimants that Delta Dental applies when a claimant has both types of x-rays is not supported by the plan provisions in the State of Montana Dental Plan booklet. The State of Montana and Delta Dental should discuss this issue and determine if the State of Montana agrees with this standard operating procedure for the payment of full mouth and panorex x-rays when billed by different providers of service. Any other claim like this one flagged by ESAS can only be considered to be processed correctly if it has been been paid at the direction of the State of Montana.

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Plan Limitations

Substantive Testing Questionnaire

Questionnaire ID:	6
Client:	Montana State - Delta Dental
Audit Period:	01/01/2013 - 12/31/2013

The above referenced individual was identified by ESAS® as having incurred claim payment(s) for conditions which are limited under this Plan.

1. The claims relating to charges for the plan limitation in question are listed below. Please provide documentation showing that the benefits for complete (full mouth) x-rays have not been exceeded based on the plan limitations.

Administrator's Response

System Processed per EBD;

Procedure D0210 Benefit is limited to one full mouth series within a 5 year period.

Procedure D0330 Benefit is limited to one panoramic film within a 5 year period.

Conclusion

A procedural error and \$80.00 overpayment have been identified. The exception to the frequency limitation for full mouth series and panorex x-rays for State of Montana claimants that Delta Dental applies when a claimant has both types of x-rays is not supported by the plan provisions in the State of Montana Dental Plan booklet. The State of Montana and Delta Dental should discuss this issue and determine if the State of Montana agrees with this standard operating procedure for the payment of full mouth and panorex x-rays when billed by different providers of service. Any other claim like this one flagged by ESAS can only be considered to be processed correctly if it has been been paid at the direction of the State of Montana.

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Plan Limitations

Substantive Testing Questionnaire

Questionnaire ID:	7
Client:	Montana State - Delta Dental
Audit Period:	01/01/2013 - 12/31/2013

The above referenced individual was identified by ESAS® as having incurred claim payment(s) for conditions which are limited under this Plan.

1. The claims relating to charges for the plan limitation in question are listed below. Please provide documentation showing that the benefits for prophylaxis have not been exceeded based on the plan limitations.

Administrator's Response

Response: System processed all claims. It appears the system processed and allowed the third D1110 incorrectly. Procedure D1110 Benefit is limited to two routine cleaning within a calendar year.

Conclusion

A procedural deficiency and \$71.00 overpayment identified. A third cleaning was paid in calendar year 2013. Any other claim like this one flagged by ESAS can only be considered correct when it has been verified that no more than two cleanings have been paid in a calendar year.

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Plan Limitations

Substantive Testing Questionnaire

Questionnaire ID:	8
Client:	Montana State - Delta Dental
Audit Period:	01/01/2013 - 12/31/2013

The above referenced individual was identified by ESAS® as having incurred claim payment(s) for conditions which are limited under this Plan.

1. The claims relating to charges for the plan limitation in question are listed below. Please provide documentation showing that the benefits for prophylaxis have not been exceeded based on the plan limitations.

Administrator's Response

Response: System processed all claims. It appears the system processed and allowed the third D1110 incorrectly. Procedure D1110 Benefit is limited to two routine cleaning within a calendar year.

Conclusion

A procedural deficiency and \$57.00 overpayment identified. A third cleaning was paid in calendar year 2013. Any other claim like this one flagged by ESAS can only be considered correct when it has been verified that no more than two cleanings have been paid in a calendar year.

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Plan Limitations

Substantive Testing Questionnaire

Questionnaire ID:	9
Client:	Montana State - Delta Dental
Audit Period:	01/01/2013 - 12/31/2013

The above referenced individual was identified by ESAS® as having incurred claim payment(s) for conditions which are limited under this Plan.

1. The claims relating to charges for the plan limitation in question are listed below. Please provide documentation showing that the benefits for prophylaxis have not been exceeded based on the plan limitations.

Administrator's Response

Response: System processed all claims. It appears the system processed and allowed the third D1110 incorrectly. Procedure D1110 Benefit is limited to two routine cleaning within a calendar year.

Conclusion

A procedural deficiency and \$71.00 overpayment identified. A third cleaning was paid in calendar year 2013. Any other claim like this one flagged by ESAS can only be considered correct when it has been verified that no more than two cleanings have been paid in a calendar year.

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Timely Filing (Last service date to process date)

Substantive Testing Questionnaire

Questionnaire ID:	10
Client:	Montana State - Delta Dental
Audit Period:	01/01/2013 - 12/31/2013

The above referenced individual was identified by ESAS® as having claims paid when the claim submission exceeded the plan limitation for timely claim filing. The claim was received 12 months after the service date and the plan requires claims to be filed within 12 months from the service date. Please provide the following information regarding this claim payment and attach it to this form:

1. Provide all documentation that supports why these claims were paid after the timely filing limit.
-

Administrator's Response

The system processed the claim and denied for time limitation in error due to division termination. Claim was approved to process due to a division change not termination.

Conclusion

No procedural deficiency or payment error identified. This claim was received within the timely filing limit as defined by the Plan. Any other claim like this one flagged by ESAS can only be considered correct if claim was received within 12 months after the service has been provided.

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Exhibit B.

**Delta Dental Response
to Working Draft Report**

1) Additional information regarding the benefit frequency for D0210 and D0330. It was discussed during implementation and the State of Montana agreed that they would change the frequency to these codes to Delta Dental's standard. Delta Dental's standard is each code D0210 and D0330 is benefitted 1 x 5 years without cross-history check.

2) No further responses.

RANDOM SAMPLE AUDIT REPORT

State of Montana INC. Medical Plans

Administered by:

Delta Dental

Audit Period: January 1, 2013 to December 31, 2013

Prepared: 4/10/2014

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RANDOM SAMPLE AUDIT REPORT

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Overview

Random Sample Audit Objectives

The objectives of the Random Sample Audit are to verify that claims are being paid in accordance with plan specifications and the administrative agreement, to measure administrative process quality versus established indicators, and to identify administrative process deficiencies for remediation or further review.

Random Sample Audit Scope

The scope of our random sample audit included remote-site review of Delta Dental's claims processing in Des Moines IA and a stratified random sample of 108 paid or denied claims for dependents with coverage under the State of Montana medical plans. The statistical confidence level of the audit sample was 95%, with a 3% margin of error. Each claim in the sample was reviewed by a CTI auditor to ensure that it conformed to the plan specifications, agreements, and negotiated discounts.

Performance was measured for seven Key Performance Indicators as follows:

- Documentation Accuracy – Financial
- Documentation Accuracy – Frequency
- Financial Accuracy
- Accurate Payment Frequency
- Adjudication Proficiency
- Accurate Processing Frequency
- Claim Turnaround

Also reported are Additional Observations regarding processes or payments beyond the scope of the Random Sample Audit. Other reported categories include Coordination of Benefits (COB) Savings, Records Retrieval and Data Coding Validity. Definitions of the Key Performance Indicators are provided later in this section along with their respective reported results.

Random Sample Audit Methodology

Each sampled claim selected for the Random Sample Audit was reviewed by a CTI auditor for conformance to the plan specifications, agreements, and negotiated discounts.

Errors were cited when a claim selected in the random sample was paid or processed incorrectly based on member eligibility or plan provisions as defined in the Summary Plan Description or amendments to it. Payment errors were observed based on the way the selected claim was paid and the information the administrator had at the time that transaction was processed; if the claim was later corrected, the error still is cited so

that focus can be placed on how to reduce errors and re-work of claims. Additional observations (not errors) were cited when processes or payments beyond the scope of the sample were observed. CTI's audit system categorizes errors into one or more of six Key Performance Indicators.

The discussion between CTI and Delta Dental of any error or additional observation made by CTI's team during the onsite review was recorded in CTI's audit system. A preliminary Random Sample Audit report was reviewed and responded to by Delta Dental and their written response was taken into consideration before producing this final report. Ultimately payment and procedural errors that remain after the written dialogue between the Claims Administrator and CTI is completed are accumulated and used to arrive at the level of performance accuracy for each Key Performance Indicators. We then review the preliminary Random Sample Audit results with the Claim Administrator before producing final reports and recommendations for the Plan Sponsor.

The process and impact of improving processes and adjusting payment errors identified through this Random Sample Audit (and in conjunction with the Operational Review and Electronic Screening and Analysis) should be discussed by the Plan Sponsor and the Claim Administrator. CTI stands ready to assist the Plan Sponsor in discussions of the Random Sample Audit results to whatever extent requested.

Random Sample Audit Findings by Key Performance Indicator

Performance, as measured by the Random Sample Audit sample for each Key Performance Indicator, is presented in the pages immediately following.

Documentation Accuracy - Financial

Operational Definition: The dollar amounts processed with documentation adequate to substantiate payment or denial compared to the dollar amounts processed in the Audit Sample.

The Audit Sample revealed 4 inadequately documented payments, representing total paid claim amounts of \$1,740.31. An inadequately documented payment does not produce enough evidence to establish that the payment amount was correct. With this in mind, CTI removes inadequately documented payment amounts from the denominator (total of correctly paid claim amounts) used to calculate other financial measures (reference Financial Accuracy and COB Savings in this report) in the audit, as that denominator assumes the payment amounts to be correct.

Documentation Accuracy - Financial for the claims sampled is 94.15%.

On a weighted, adjusted basis for the audit universe Documentation Accuracy - Financial is 96.01%.

Each error found in the Random Sample Audit is listed in the following report titled, "Documentation Accuracy – Financial and Frequency" Error Detail Report.

CTI Error Detail Report

Documentation Accuracy - Financial and Frequency

Client: Montana State - Delta Dental
Audit 1/1/2013 - 12/31/2013
Audit Numbers: 1001 - 1108

Run Date: 3/20/2014

Page 1 of 1

CTI Audit No: Claim No.

Error Type	Line No.	Question Description	Error Indicator and Description	Info Indicator and Description	Charge Amt	Paid Amt	
1010 ADJUD	20132063400257-20130814 COB Investigation	OINI	Other insurance not investigated	OI	Other insurance indicated in file	\$258.00	\$141.20
1038 ADJUD	20133503407717-20131223 001 Policy Provisions	SPAI	Should have been pended for additional medical information			\$1,790.00	\$850.00
1039 ADJUD	20131423400355-20130529 COB Investigation	OIDI	Other insurance documentation inadequate	OI	Other insurance indicated in file	\$481.00	\$336.60
1066 ADJUD	20130743402131-20130327 001 Policy Provisions	SPAI	Should have been pended for additional medical information			\$1,000.00	\$412.50
Total Number of Claims: 4						\$3,529.00	\$1,740.30

Documentation Accuracy - Frequency

Operational Definition: The number of claims processed with documentation adequate to substantiate payment or denial compared to the total number of claims processed in the Audit Sample.

An inadequately documented claim does not produce enough evidence to establish that payment or denial of the claim was correct. With this in mind, CTI removes inadequately documented claims from the denominator (total of correctly paid claims) used to calculate accurate payments (reference Accurate Payment Frequency in this report) in the audit, as that denominator assumes the payments to be correct.

Documentation Accuracy -- Frequency for the audit sample is 96.30%.

Each error found in the Random Sample Audit is listed in the Error Detail Report titled: "Documentation Accuracy – Financial and Frequency" which can be found in the preceding section.

Financial Accuracy

Operational Definition: The total correct claim payments that were made compared to the total dollars of correct claim payments that should have been made for the Audit Sample. The formula for this measure is: Total correct payments (claims paid in the sample minus overpayments plus underpayments) minus the absolute variance (overpayments plus underpayments), divided by total correct payments.

Claims sampled and reviewed by CTI revealed \$533.00 in underpayments and \$0.00 in overpayments, for a combined variance of \$533.00. The correct payment total for the 104 remaining claims, after the 4 claims removed for insufficient documentation in the audit sample, should have been \$28,541.68.

Financial Accuracy for the claims sampled is 98.13%.

On a weighted, adjusted basis for the audit universe Financial Accuracy is 99.07%.

Each error found in the Random Sample Audit is listed in the following Error Detail Report titled "Financial Accuracy and Accurate Payment Frequency."

CTI Error Detail Report

Financial Accuracy and Accurate Payment Frequency

Client: Montana State - Delta Dental
Audit 1/1/2013 - 12/31/2013
Audit Numbers: 1001 - 1108

Run Date: 3/20/2014
Page 1 of 1

Primary Indicator Description
Cause

	CTI AuditNo.	Claim No.	Entered Amount	Correct Amount	Under Paid	Over Paid
DEE	Denied eligible expense					
	1020	20132943409695-	\$618.88	\$1,055.88	(\$437.00)	\$0.00
	Subtotal: 1		\$618.88	\$1,055.88	(\$437.00)	\$0.00
OPEI	Other insurance payment entered incorrectly					
	1076	20131723401432-	\$80.00	\$176.00	(\$96.00)	\$0.00
	Subtotal: 1		\$80.00	\$176.00	(\$96.00)	\$0.00
Total Number of Claims:	2				(\$533.00)	\$0.00

Accurate Payment Frequency

Operational Definition: Accurate Payment Frequency compares the number of bills paid correctly to the total number of bills paid for the Audit Sample.

The Audit Sample revealed 2 incorrectly paid bills and 102 correctly paid bills. The incorrectly paid bills were comprised of 2 underpaid bills and no overpaid bills.

Accurate Payment Frequency for the claims sampled is 98.08%.

Each error found in the Random Sample Audit is listed in the Error Detail Report shown in the preceding Error Detail Report titled “Financial Accuracy and Accurate Payment Frequency.”

Adjudication Proficiency

Operational Definition: The number of correct adjudication decisions made compared to the total number of adjudication decisions required for the bills in the Audit Sample.

861 separate decisions were reviewed during the audit. An average of 8.3 decisions for each bill was reviewed to determine Adjudication Proficiency. 8 adjudication errors were observed in the Audit Sample.

Adjudication Proficiency for the claims sampled and all claims in the universe is 99.07%.

The adjudication errors found in the Random Sample Audit are shown in the following “Adjudication Proficiency” Error Detail Report. Adjudication errors can result in payment errors and/or may have been the result of inadequate documentation. To the extent that this has occurred, the same CTI Audit Numbers may appear on both the following Error Detail Report titled “Adjudication Proficiency” as well as that preceding entitled “Financial Accuracy and Documentation Accuracy – Financial.”

CTI Error Detail Report Adjudication Proficiency

Client: Montana State - Delta Dental
Audit 1/1/2013 - 12/31/2013
Audit Numbers: 1001 - 1108

Run Date: 3/20/2014
Page 1 of 1

Error Type	Question Description	Indicator	Indicator Description	Examiner Flag	CTI Audit	LineNo.	Provider ID
ADJUD	COB Investigation	OIDI	Other insurance documentation inadequate		1039		
ADJUD	COB Investigation	OINI	Other insurance not investigated		1010		
ADJUD	COB Investigation	OINI	Other insurance not investigated		1020		
	3 COB Investigation						
ADJUD	COB Adjud	OPEI	Other insurance payment entered incorrectly		1076		
	1 COB Adjud						
ADJUD	Policy Provisions	DEE	Denied eligible expense		1020	006	
ADJUD	Policy Provisions	DL	Dollar limits not applied		1012	001	
ADJUD	Policy Provisions	SPAI	Should have been pended for additional medical information		1038	001	
ADJUD	Policy Provisions	SPAI	Should have been pended for additional medical information		1066	001	
	4 Policy Provisions						

Examiner Error: 8
System Error: 0
Total Count: 8

Accurate Processing Frequency

Operational Definition: The number of bills processed without errors compared to the total number of bills processed in the Audit Sample.

When a bill has errors found in more than one category, it is counted only once as a single incorrect bill for this measure.

The Audit Sample revealed 101 bills processed without any type of error, while 7 bills had one or more errors.

Accurate Processing Frequency for the sample and all claims in the universe is 93.52%.

There is no Error Detail Report for this performance indicator since the specific errors are referenced in respect to other measures in this report.

Claim Turnaround

Operational Definition: The number of calendar days required to process a claim -- from the date the claim is received by the administrator to the date a payment, denial, or additional information request is processed -- expressed as both the Mean Average and Median for the Audit Sample.

Median Claim Turnaround Time for the claims sampled was 1 day from *Date Received by the Claim Administrator to Date Claim Processed*. Same day turnaround on claims is the fastest turnaround time that can be achieved, but is not necessarily the best turnaround time. The claim administrator should balance claim turnaround by handling all types of claims as efficiently as possible.

A detailed Claim Turnaround Analysis is presented in the following report titled “Claim Turnaround Analysis.”

NOTE: Claim administrators commonly measure Claim Turnaround Time in Mean Average Days. Median Days, however, is a more meaningful measure for the administrator to focus on when analyzing Claim Turnaround because it prevents one or a few claims with extended Turnaround Time(s) from distorting the true performance picture. The Mean Average Claim Turnaround from *Date Received* to *Date Processed* was 3 days.

CTI Claim Turnaround

Paid and Pended

Client: Montana State - Delta Dental
 Audit Period: 1/1/2013 - 12/31/2013
 Audit Numbers: 1001 - 1108

Run Date: 3/20/2014
 Page 5 of 5

Audit	Claim Number	Last Service	To	Date Signed	To	Date Complete Cln Rcvd by	To	Process Date	To	Date EOB/Ck Mailed	Total Days
*Pended Claims Averages:			0		0		0		0		0
Non-Pended Claims Averages:			0		14		3		7		25
Combined Averages (Pended && Non-Pended):			0		14		3		7		25

Number of Days Between Received and Processed Dates:

1 Day.	55	26 Days.	0
2 Days.	10	27 Days.	0
3 Days.	15	28 Days.	0
4 Days.	12	29 Days.	0
5 Days.	6	30 Days.	0
6 Days.	4	31 Days.	0
7 Days.	1	32 Days.	0
8 Days.	0	33 Days.	0
9 Days.	0	34 Days.	0
10 Days.	0	35 Days.	0
11 Days.	1	36 Days.	0
12 Days.	0	37 Days.	0
13 Days.	0	38 Days.	0
14 Days.	0	39 Days.	0
15 Days.	1	40 Days.	0
16 Days.	0	41 Days.	0
17 Days.	1	42 Days.	0
18 Days.	0	43 Days.	0
19 Days.	1	44 Days.	0
20 Days.	1	45 Days.	0
21 Days.	0	> 45 Days.	0
22 Days.	0	Undetermined:	0
23 Days.	0	Total Number of Claims:	108
24 Days.	0		
25 Days.	0	Days:	

Median: 1



Additional Observations and Results

During the course the of audit, procedures or situations may be observed which may not have caused an error on the sampled claim, but which may have impact on future claims or the overall quality of service.

ADDITIONAL OBSERVATIONS	CTI AUDIT #
This member's benefits accumulation appears to include Diagnostic & Preventative (D&P) services incurred throughout the year. Delta Dental has provided to CTI email documentation of a plan change requested by the State of Montana in which the State has authorized Delta Dental to waive D&P services from accumulating to the member plan maximum. The State of Montana should be made aware that this plan change was not applied retro-actively on all plan members, but only in cases that were reported to them.	1001
Based upon the Delta Dental response, this member has exceeded the plan's oral exam threshold and the oral exam dated 8/15/2013 should have been denied by Delta Dental.	1009
The State of Montana should be made aware of the claims system processing hierarchy used by Delta Dental. In this case the x-ray requirement for this implant procedure superseded any review of the plan maximums being exhausted.	1101

ADDITIONAL AUDIT RESULTS	
COB Savings (weighted)	1.88%*
% of Claims Selected for Audit Sample for Which Complete Records Were Produced	100%**
Data Coding Validity	100%***

*Coordination of Benefits (COB) Savings was calculated based on the audit sample using the claim dollars saved by the plan through coordination with other group plans and Medicare as a percentage of the correct total claim dollars paid. The Random Sample Audit further indicated that COB Savings, if all claims had been coordinated correctly, would have been 1.58% of paid claims.

**108 claims initially were requested for the Audit Sample. Delta Dental provided documentation of 100% of the claims requested.

***A total of 1,517 data elements were verified in the audit. The sample revealed no coding or data entry errors.

Exhibits

A. Random Sample Audit Sample Construction and Weighting

B. Random Sample Audit Observation/Response Forms

C. Delta Dental Audit Response

Exhibit A.

Sample Construction and Weighting Methodology

Client: Montana State - Delta Dental

Audit Period: January 01, 2013 - December 31, 2013

Claim Universe (as converted)

Stratum	Claim Count	Total Charge Amount	Total Paid Amount
1	43,212	\$5,715,072	\$3,744,401
2	9,500	\$4,677,940	\$1,944,701
3	3,545	\$6,534,609	\$1,733,310
Total	56,257	\$16,927,622	\$7,422,412

Audit Stratification

Stratum	Audit Universe (# Claims)	Proportion (Weight by Count)	Sample
1	43,212	76.81%	36
2	9,500	16.89%	36
3	3,545	6.30%	36
Total	56,257	100.00%	108

Audit Sample Overview

<u>Category</u>	<u>Count</u>	<u>Paid</u>
Claims requested for audit	108	\$29,748.98
Claims for which records not received	0	\$0.00
Claims outside scope of audit	0	\$0.00
Claims as entered included in audit sample	108	\$29,748.98
Audit sample if all claims paid correctly	108	\$30,281.98
Claims with inadequate documentation	4	\$1,740.30
Total claim payments remaining in audit sample	104	\$28,541.68

Exhibit B.

Random Sample Audit Observation/Response Forms

Run Date: 3/20/2014 2:33:56 PM
Claim No:20131556070888-20130612
Employee Relation: D
Conclusion Date: 03/19/2014

A. This member's calendar benefits usage on file states \$537.00. This member's benefits accumulation appears to include Diagnostic & Preventative (D&P) services incurred throughout the year. Delta Dental has provided to CTI email documentation of a plan change requested by the State of Montana in which the State has authorized Delta Dental to waive D&P services from accumulating to the member plan maximum. The State of Montana should be made aware that this plan change was not applied retro-actively on all plan members, but only in cases that were reported to them.

RESPONSE

1

Agree with Error(s)

Disagree with Error(s)
(State Reasons Below)

A. Delta Dental disagrees with this error. There were discussions with the State of Montana regarding the addition of the Diagnostic and Preventive Maximum Waiver mid-year and they agreed that Delta Dental would not have to re-process all claims retroactively to 1/1/2013. Re-processing of claims was done on a 'complaint-basis'.

CONCLUSION

A. Additional observation only: This member's benefits accumulation appears to include Diagnostic & Preventative (D&P) services incurred throughout the year. Delta Dental has provided to CTI email documentation of a plan change requested by the State of Montana in which the State has authorized Delta Dental to waive D&P services from accumulating to the member plan maximum. The State of Montana should be made aware that this plan change was not applied retro-actively on all plan members, but only in cases that were reported to them.

FOR CTI INTERNAL USE ONLY

FinAccum
FinPrimary

IDOC Primary

Code	Line No	Over/Under	ProvID	EEF	Error
OTIP1					INFO
CSBU					INFO

Desc	Internal Procedures
COB Information	

Strictly Private and Confidential

AUDIT OBSERVATION / RESPONSE FORM

Client: Montana State - Delta Dental
Audit Period: 1/1/2013 - 12/31/2013
Audit No: 1009
Auditor: David Bade

Run Date: 3/20/2014 2:33:56 PM
Claim No: 20131763402347-20130703
Employee Relation: D
Conclusion Date: 03/18/2014

OBSERVATION 1 TO:

Additional observation only: CTI notes that this member had three oral exams in 2013. The first was for a comprehensive oral evaluation, while the second and third were for problem focused exams. Please explain how Delta Dental accumulates oral examination toward the two per calendar year limit. It appears this member has exceeded this exam threshold.

RESPONSE 1 Agree with Error(s) Disagree with Error(s)
(State Reasons Below)

A. Delta Dental disagrees with this error. The State of Montana frequency limitation for exams is no more than two per calendar year. This includes procedure codes D0120, D0140, D0145, D0150, D0160, D0180 and D9310.

CONCLUSION

Additional observation only: Based upon the Delta Dental response, this member has exceeded the plan's oral exam threshold and the oral exam dated 8/15/2013 should have been denied by Delta Dental.

FOR CTI INTERNAL USE ONLY

Code	Line No	Over/Under	Provid	EEF	Error	FinAccum	IDOC Primary
OTIP1					INFO	FinPrimary	
CSBU					INFO	Desc	
						Internal Procedures	
						COB Information	

Strictly Private and Confidential



AUDIT OBSERVATION / RESPONSE FORM

Client: Montana State - Delta Dental
Audit Period: 1/1/2013 - 12/31/2013
Audit No: 1010
Auditor: David Bade

Run Date: 3/20/2014 2:33:56 PM
Claim No: 20132063400257-20130814
Employee Relation: E
Conclusion Date: 03/19/2014

OBSERVATION 1 TO:

A. The documentation provided indicates there is other insurance coverage for this claimant. Without documentation showing what the source is for this claimant's other insurance coverage, CTI will cite an adjudication error and the claim will be removed from the total accumulation of correct payments.

B. Please advise the Delta protocol for rebundling multiple bitewings services. This provider of service billed for two bitewings and also for 4 vertical bitewings. Delta rebundled these charges and limited the benefit to that of four bitewings

RESPONSE 1 Agree with Error(s) Disagree with Error(s)
(State Reasons Below)

A. Delta Dental disagrees with this error. Per the claim submitted it indicates that this patient has two coverages; one with Delta Dental Insurance Company and the other with Delta Dental of California. The remarks on the claim indicate that Delta Dental Insurance Company is the Primary Payee. The claim paid as primary.

In addition, our internal cob indicator indicates this plan as Primary.

B. Delta Dental disagrees with this error. The provider billed for both procedure code D0272 which is 2 bitewings and procedure code D0274 which is 4 bitewings. Delta Dental only paid the procedure code D0274 because per our policy only one set of bitewings per day is allowed. This was limited since both procedure codes were done on the same date of service.

CONCLUSION

A. CTI will continue to cite an adjudication error and the claim will be removed from the total accumulation of correct payments. No investigation was done by Delta Dental to confirm the comment provided by the provider "YOU ARE THE PRIMARY PAYOR-PLEASE REPROCESS". If any confirmatory investigation was done, no supporting documentation was provided.

B. No error.

FOR CTI INTERNAL USE ONLY				EEF	Error	FinAccum	OINI	IDOC	Primary
Code	Line No	Over/Under	ProvID	ADJUD	INFO	FinPrimary	Desc	COB Investigation	COB Information
OINI									
OI									

Strictly Private and Confidential



Client: Montana State - Delta Dental
Audit Period: 1/1/2013 - 12/31/2013
Audit No: 1012
Auditor: David Bade

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AUDIT OBSERVATION / RESPONSE FORM

Client: Montana State - Delta Dental

Run Date: 3/20/2014 2:33:56 PM

Audit Period: 1/1/2013 - 12/31/2013

Claim No: 20132943409695-20131106

Audit No: 1020

Employee Relation: E

Auditor: David Bade

Conclusion Date: 03/19/2014

OBSERVATION 1 TO:

A. The documentation provided indicates there is other insurance coverage for this employee. It appears that the employee is an active employee with both the State of Montana and Federal Express. Please explain how Delta Dental determined that the Cigna Insurance would assume primary payor responsibility for this claim. Without documentation showing that this Delta Dental is the secondary payor this member, CTI will cite an adjudication error and the claim will be removed from the total accumulation of correct payments.

B. Eligible expenses for a coronectomy (CDT D7251) were denied on this claim. Please advise the plan provision being used for the denial of this service. CTI will cite an adjudication error a \$437.00 underpayment.

C. There was an incorrect coinsurance on this claim. The services for CDT D7240 and one of D9241 were considered at 100% rather than 80%. CTI will cite an adjudication error and a \$71.25 underpayment.

RESPONSE 1

Agree with Error(s)

Disagree with Error(s)
(State Reasons Below)

A. Delta Dental disagrees with this error. Delta received an EOB from CIGNA indicating Primary Payment.

B. Delta Dental disagrees with this error. This not a standard benefit for our plans, unless requested by the Group.

C. Delta Dental disagrees with this error. D7240 paid \$170.53 and other insurance carrier paid \$170.52, the benefit syntax within our system does not allow more than 80% of this benefit to be paid. As calculated, this benefit did not exceed 80%. The display shows 100%, because the claim was made whole with both payments. You will notice on the EOB, the patient responsibility displays \$0.00.

D9241 paid \$118.75 and other insurance paid \$118.75 which was up to the allowed amount, the benefit syntax within our system does not allow more than 80% of the benefit to be paid. As calculated, this benefit did not exceed 80%. The display shows 100%, because the claim was made whole up to the allowed amount. You will notice on the EOB, the patient responsibility display \$12.50 the difference between the allowed and approved.

CONCLUSION

A. CTI will continue to cite an adjudication error. No investigation was done by Delta Dental to confirm the payment order between this State of Montana employee's two insurance coverages.

AUDIT OBSERVATION / RESPONSE FORM

Client: Montana State - Delta Dental
Audit Period: 1/1/2013 - 12/31/2013
Audit No: 1020
Auditor: David Bade

Run Date: 3/20/2014 2:33:56 PM
Claim No: 20132943409695-20131106
Employee Relation: E
Conclusion Date: 03/19/2014

CONCLUSION (cont'd)

It appears that the provider of service billed Cigna Dental coverage first and then sent to Dental Dental for coordination. If any confirmatory investigation was done, no supporting documentation was provided.

B. CTI will continue to cite an adjudication error and \$437.00 underpayment. Per page 82, Item 5.g. this plan covers "Oral surgeries that are not covered under Chapter III – Medical Benefits. The types of surgeries that are excluded from dental benefits because they are considered medical procedures are listed in IV.A.7, provision a.

C. No error.

Code	Line No	Over/Under	ProvID	EEF	Error Desc
DEE	006		ADJUD	Policy Provisions	
FUP	005		(\$218.50)	FINANCE	Financial
FUP	006	(\$218.50)	FINANCE	Financial	
OINI			ADJUD	COB Investigation	
OI			INFO	COB Information	
		(\$437.00)			

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AUDIT OBSERVATION / RESPONSE FORM

Client: Montana State - Delta Dental
Audit Period: 1/1/2013 - 12/31/2013
Audit No: 1038
Auditor: David Bade

Run Date: 3/20/2014 2:33:57 PM
Claim No: 20133503407717-20131223
Employee Relation: E
Conclusion Date: 03/19/2014

OBSERVATION 1 TO:

A. This claim for dentures is not eligible for benefits. This claim for an upper and lower denture presents as an initial placement, however no record of any extractions for this member can be found. As such, CTI will cite an adjudication error and an \$850.00 overpayment.

RESPONSE 1 Agree with Error(s) Disagree with Error(s)
(State Reasons Below)

A. Delta Dental does not agree with this error. The State of Montana dental contract does not include a missing tooth clause; therefore, there is no need to have prior history of the extraction.

CONCLUSION

A. CTI will continue to cite an adjudication error and the claim will be removed from the total accumulation of correct payments. This plan does have a replacement clause; page 82 Item 6 d., states "Initial dentures and replacement dentures, limited to no more than one set of replacement dentures every five years." The fact that there is no record of any extractions on file for this patient should have prompted Delta Dental to verify that this indeed was the initial installation of a denture. It seems unlikely that the member was edentulous and that this was an initial placement of a denture.

FOR CTI INTERNAL USE ONLY

Code	Line No	Over/Under	Provid	EEF	Error	FinAccum	SPAI	IDOC	Primary
SPAI	001				ADJUD	FinPrimary			
						Desc			
						Policy Provisions			

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AUDIT OBSERVATION / RESPONSE FORM

Client: Montana State - Delta Dental
Audit Period: 1/1/2013 - 12/31/2013
Audit No: 1039
Auditor: David Bade

Run Date: 3/20/2014 2:33:57 PM
Claim No: 20131423400355-20130529
Employee Relation: D
Conclusion Date: 03/19/2014

OBSERVATION 1 TO:

A. The documentation provided indicates there is other insurance coverage for this claimant. The claim presents with other insurance information showing that The State of Montana member has other insurance through Aetna; the policyholder/subscriber and date of birth of the policyholder is the same as the State of Montana subscriber. How does Delta know which of the plans for this subscriber is the primary payor? The investigation into other potential insurance coverage for this claimant is incomplete. Please provide documentation that shows that the State of Montana policy is the primary payor. This results in an adjudication error and the claim will be removed from the total accumulation of correct payments.

RESPONSE 1 Agree with Error(s) Disagree with Error(s)
(State Reasons Below)

A. Delta Dental disagrees with this error. The keyer did correctly mark the claim as COB. Since there are no COB dollars on the claim and no MOSA record in MTV, the system processed the claim as primary which is correct.

CONCLUSION

A. CTI will continue to cite an adjudication error and the claim will be removed from the total accumulation of correct payments. Delta Dental should have requested a copy of the Aetna explanation of benefits to verify the payment or denial of these services by Aetna.

FOR CTI INTERNAL USE ONLY					FinAccum	OIDI	IDOC Primary
Code	Line No	Over/Under	Provid	EEF	Error	Desc	
OIDI					ADJUD	COB Investigation	
OI					INFO	COB Information	

Strictly Private and Confidential



Run Date: 3/20/2014 2:33:57 PM
Claim No:20130743402131-20130327
Employee Relation: E
Conclusion Date: 03/19/2014

A. Additional information regarding this upper denture should have been requested prior to the processing of this claim. The claim presents as an initial prosthetic device, however there is no evidence of any extractions in this member's history. An adjudication error will be cited and the claim will be removed from the total accumulation of correct payments.

RESPONSE

1

Agree with Error(s)

Disagree with Error(s)

(State Reasons Below)

A. Delta Dental disagrees. The State of Montana contract does not have a missing tooth clause; therefore, there would not be any history check of extractions to process the claim.

A. CTI will continue to cite an adjudication error and the claim will be removed from the total accumulation of correct payments. This plan does have a replacement clause; page 82 Item 6 d., states "Initial dentures and replacement dentures, limited to no more than one set of replacement dentures every five years." The fact that there is no record of any extractions on file for this patient should have prompted Delta Dental to verify that this indeed was the initial installation of a denture. It seems unlikely that the member was edentulous and that this was an initial placement of a denture.

FOR CTI INTERNAL USE ONLY

FinAccum
FinPrimary

SPAI IDOC Primary

Code
SPAI

Line No
001

Over/Under

ProvID

EEF

Error

ADJUD

Desc

Policy Provisions

AUDIT OBSERVATION / RESPONSE FORM

Client: Montana State - Delta Dental
Audit Period: 1/1/2013 - 12/31/2013
Audit No: 1076
Auditor: David Bade

Run Date: 3/20/2014 2:33:57 PM
Claim No: 20131723401432-20130717
Employee Relation: D
Conclusion Date: 03/19/2014

OBSERVATION 1 TO:

A. The payment from the father's insurance carrier was entered incorrectly as the primary payment for this patient. The birthday rule indicates that the State of Montana employee should be the primary payor for this patient as this dependent resides with the State of Montana employee. CTI will cite an adjudication error and \$176.00 overpayment.

RESPONSE 1 Agree with Error(s) Disagree with Error(s)
(State Reasons Below)

A. Delta Dental disagrees with this error. Delta Dental received an EOB from Delta Dental of Washington indicating Primary Payment. Based on this and the fact that this dependent's parents have different last names the birthday rule would not be applied.

CONCLUSION

A. CTI will continue to cite an adjudication error and \$96.00 underpayment. No investigation was done by Delta Dental to confirm the payment order between this State of Montana employee and this dependent child's father. On page 95, Item 1 c. iii., the plan booklet states "When parents are separated or divorced, the birthday rules do not apply. Instead:

- a) The plan of the parent with custody pays first;
- b) The plan of the spouse of the parent (step-parent) pays next; and
- c) The plan of the parent without custody pays last.

Based on the information known at this time, the State of Montana employee has the primary insurance unless a divorce decree stipulates otherwise. If any confirmatory investigation was done, no supporting documentation was provided.

FOR CTI INTERNAL USE ONLY				FinAccum		IDOC Primary
Code	Line No	Over/Under	Provid	EEF	OPEI	FinPrimary
FUP	001	(\$11.00)		FINANCE		Desc
FUP	002	(\$29.00)		FINANCE		Financial
FUP	003	(\$17.00)		FINANCE		Financial
FUP	004	(\$39.00)		FINANCE		Financial
OPEI				ADJUD		COB Adjud
OI				INFO		COB Information
		(\$96.00)				

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AUDIT OBSERVATION / RESPONSE FORM

Client: Montana State - Delta Dental
Audit Period: 1/1/2013 - 12/31/2013
20130227

Run Date: 3/20/2014 2:33:57 PM
Claim No: 20130506035628-

Audit No: 1101
Auditor: David Bade

Employee Relation: E
Conclusion Date: 03/19/2014

OBSERVATION 1 TO:

A. The requested information for this implant procedure was not necessary; the member had already exhausted the plan's \$1500.00 lifetime maximum on the service incurred 4/26/2012. The provider of service complied with the request for x rays only to have the claim denied later as the member had exhausted the plan implant maximum. CTI will cite an adjudication error.

RESPONSE 1 Agree with Error(s) Disagree with Error(s)
(State Reasons Below)

A. Delta Dental disagrees with this error. The x-ray requirement for these procedure codes is reviewed prior to consideration of any maximum review is done according to policy.

CONCLUSION

A. Additional observation only: The State of Montana should be made aware of the claims system processing hierarchy used by Delta Dental. In this case the x-ray requirement for this implant procedure superseded any review of the plan maximums being exhausted.

FOR CTI INTERNAL USE ONLY

FinAccum
FinPrimary

IDOC Primary

Code	Line No	Over/Under	Provid	EEF	Error	Desc
OTIP1	INFO				Internal Procedures	

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Exhibit C.

Delta Dental's Audit Observation Responses

Delta Dental does not have any further responses to the random sample audit reports.

